

Division of Long Term Care Publication

Indiana Long Term Care Leadership Conference

On October 10, 2007, the Indiana State Department of Health hosted a conference for health care providers to address the problem of pressure ulcers. The conference was attended by 1,097 health care provider representatives. According to the 2006 Medical Errors Reporting System (MERS) report, 26 of the 85 reported events were stage 3 or 4 pressure ulcers acquired after admission to the facility.

Health officials say pressure ulcers are an example of a system-based problem and that is not uncommon for a pressure ulcer to develop in one facility and become worse or be treated in another facility.

"The purpose of the conference was to bring together representatives of all parts of the health care system, including hospitals and nursing homes, to start a dialogue on how the system can be improved to prevent pressure ulcers," said State Health Commissioner Judy Monroe, M.D. "Thanks to the Medical Errors Reporting System, we were able to identify pressure ulcers as a leading cause of medical errors in Indiana and can now better address the problem."

To assist nursing homes in the prevention of pressure ulcers, the Indiana State Department of Health is contracting with Hill-Rom to provide one alternating pressure, low air loss-mattress to every nursing home in the state. The Indiana State Department of Health is also contracting with EHOB to provide 4 pressure-reducing wheelchair cushions to every nursing home in the state.

The conference included national presenters on pressure ulcer reduction initiatives and experts discussed best practices for ulcer prevention and treatment. Representatives from all Indiana hospitals, nursing homes, patient care organizations, and state health surveyors were invited to attend.



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New CMS Principal Program Representative for Indiana

Tamika Brown became the Indiana Principal Program Representative on November 13, 2007, replacing Heather Lang, who will now serve as the Non-Long Term Care Principal Program Representative. Tamika will also continue to serve as the Long Term Care Principal Program Representative for Illinois.



CNA, HHA & QMA Renewals

The renewal process for CNA's, HHA's and QMA's will be changing in January 2008. The main difference is that CNAs HHAs and QMAs will be required to update themselves. They will have the option to renew online or by paper. A copy of the letter sent on December 3, 2007 notifying all facilities of this change is on page 8.

Magnetic Door Locks

Magnetic door locks must have the following provisions:

They must be interconnected with the facility's fire alarm system. The doors must unlock with initiation of the fire alarm system and only reset when the alarm is reset. They must be provided with a means to release. This can be a key pad or keyed release to which all staff has a key. If the magnetic door lock is activated with a 15 second delay, a sign must be posted at the door stating such. No more than one of these locking arrangements can be used in any single path of egress (exit way).

Magnetic door locks should only be used in special care units. Other residents need to be able to come and go through these doors. If they are used in a mixed occupancy, then, all staff and responsible residents must know the code. Special care units housing dementia, etc. residents can have the locks without residents knowing the code. Wander Guard type systems can be used without residents knowing the code. Delayed egress locks can be used in any area provided they meet the requirements of the first paragraph.

RN and LPN License Renewals

Prevention and Control of Influenza/
Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2007:

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5606a1.htm?s_cid=rr5606a1_e



Beginning September 1, 2007 licenses for RN's and LPN's will no longer have an expiration date. Facilities are expected to have documentation in their records showing that RN's and LPN's have renewed their licenses. Indiana Professional Licensing requires RN's and LPN's to renew their license every two years. Facilities can verify current licensure and expiration date on the IPLA website, <http://www.in.gov/pla/>. Per 42 CFR 483.75(g) and 410 IAC 16.2-3.1-14(s) RN's and LPN's are not allowed to work if their license has not been renewed.



Plan of Correction Guidance

The Indiana State Department of Health, Long Term Care Division is now providing additional guidance to assist facilities with the development of their plan of correction. The intent is to provide guidelines to eliminate the need for an addendum. A copy of the “Plan of Correction Guidance” that is sent with the CMS-2567L’s can be found on page 10.

New construction, additions, or remodeling

Prior to the commencement of any construction or remodeling at a facility or beginning construction on a new facility please ensure that any plans and specifications for that project have been approved (if required) by the Indiana State Department of Health, Division of Sanitary Engineering. The general rule is that any new construction, addition, conversion, relocation, renovation, and/or any major change in facility physical plant would require plans approval. To determine if plans are required to be submitted for any project you should contact the Division of Sanitary Engineering at 317/233-7588.

Also before beginning the construction or remodeling project the facility should contact the Provider Services Program Director to determine if supplemental application forms or supporting documentation is required for the transaction. New facilities, bed additions, conversions, facility relocations, remodeling projects, etc. might have both state and federal requirements in addition to plans approval.

After construction is complete and before occupying the area of construction or remodeling, contract the Provider Services Program Director to verify that all application materials and/or requirements have been met. Then submit a “Statement of Substantial Completion – Request for Inspection” (State Form 13025) or a letter to the Provider Services Program Director. In addition, the facility shall also notify the Program Director in writing when the new construction or remodeled area is ready for the required Sanitarian and Life Safety Code/State Fire Code inspections. The area cannot be occupied until these inspections have been conducted and the Division of Long Term Care has issued the authorization to occupy.



Initial Medicare Surveys

On November 5, 2007 Centers for Medicare and Medicaid Services (CMS) released Survey & Certification memo 08-03 informing state agencies of a change for new suppliers requesting initial certification in the Medicare Program. CMS is no longer budgeted to conduct initial long term care facility certification surveys due to limited resources. This change in policy was effective November 5, 2007.

For the past three consecutive years the final federal budget for Medicare survey and certification has been considerably less than the level requested. Many additional providers have been seeking to participate in the Medicare program and there are additional survey responsibilities that have further stretched resources. These have increased the need to pay careful attention to survey priorities. Longstanding CMS policy makes complaint investigations, recertifications, and core infrastructure work for existing Medicare providers a higher priority compared with certification of new Medicare Providers. The Survey & Certification memo 08-03 can be found on page 61.



Are you looking for a way to improve your health or the health of your family, staff, or patients? If so, you need to know about INShape Indiana and how to get involved.

INShape Indiana is Governor Mitch Daniels' statewide health initiative aimed at helping Hoosiers make healthy choices by linking them to valuable resources and offering a fun challenge to improve their health and well-being. INShape Indiana is not another program; it is an initiative to coordinate the many efforts taking place across the state to combat obesity and smoking.

The sad truth is that Indiana currently ranks 10th in obesity and 2nd in adult smoking. The poor health outcomes associated with obesity and smoking negatively impact the health of Hoosiers as well as the state's economy.

INShape Indiana promotes three simple health messages:

- Better nutrition
- Increased physical activity
- Stopping smoking

Log on to www.INShape.IN.gov to access the clearinghouse of information on programs, activities, and events from all over the state related to nutrition, physical activity, and tobacco cessation. You can also register to be an INShape Indiana participant and use the bi-weekly tracking mechanism to monitor your progress towards a healthier lifestyle. All participants have access to the incentives provided by the INShape Indiana partners. The website also offers the opportunity to celebrate individual and group success stories so be sure to tell us about your successes!

You will also want to check out the Health After 50 section of the INShape Indiana website. This section provides information on nutrition, physical activity, and wellness issues tailored to the needs of Hoosiers 50 years and older. This can be a great resource for Long Term Care facilities and the residents. Be sure to check future editions of this newsletter for specific tips on helping those over 50 to lead healthy, active lifestyles.



Indiana State Department of Health

LTC News is published by the
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Long Term Care*

Long Term Care Bi-weekly Newsletter

Beginning in January 2008, the ISDH will begin a bi-weekly Long Term Care Newsletter. Anyone can subscribe to this newsletter and there is no cost. We encourage anyone who is interested in long term care to subscribe to the Long Term Care Newsletter. Go to this address today to subscribe:

<http://www.in.gov/isdh/regsvcs/ltc/ltcnewsletter/index.htm>

Public Health Notification from FDA: Vail Products
Enclosed Bed Systems (updated December 2007)

<http://www.fda.gov/cdrh/safety/120407-vail.html>



Indiana State Department Of Health Division of Long Term Care



TELEPHONE GUIDE

Arranged alphabetically by subject

All are Area Code 317

SUBJECT	CONTACT PERSON	EXTENSION
Administrator/DON, Facility Name/Address Changes	Miriam Buffington	233-7613
Bed Change Requests (Changing/Adding Licensed Bed/Classifications)	Miriam Buffington	233-7613
CNA Registry	Automated	233-7612
CNA Investigations	Brenda Meredith	233-7321
CNA/QMA Training	Nancy Adams	233-7480
Director, Division of Long Term Care	Suzanne Hornstein	233-7289
Enforcement & Remedies	Miriam Buffington	233-7613
Facility Data Inquiries	Sarah Roe	233-7904
FAX, Administration		233-7322
Incidents/Unusual Occurrences	Fax	233-7494
	Voicemail	233-5359
	Other	233-7442
Informal Dispute Resolution	Susie Scott	233-7651
License/Ownership Verification Information	Miriam Buffington	233-7613
License Renewal	Miriam Buffington	233-7613
Licensed Facility Files (Review/Copies)	Darlene Jones	233-7351
Licensure & Certification Applications/Procedures (for New Facilities and Changes of Ownership)	Miriam Buffington	233-7613
Life Safety Code	Rick Powers	233-7471
MDS/RAI Clinical Help Desk	Gina Berkshire	233-4719
MDS Technical Help Desk	Technical Help Desk Staff	233-7206
Monitor Program	Debbie Beers	233-7067
Plans of Correction (POC), POC Extensions & Addenda	Area Supervisors	See Below
Plans & Specifications Approval (New Construction & Remodeling)	Dennis Ehlers	233-7588
Rules & Regulations Questions	Debbie Beers	233-7067
Survey Manager	Kim Rhoades	233-7497
Transfer/Discharge of Residents	Miriam Buffington	233-7613
Unlicensed Homes/Facilities	Linda Chase	233-7095
Waivers (Rule/Room Size Variance/ Nursing Services Variance)	Miriam Buffington	233-7613
Web Site Information	Sarah Roe	233-7904
AREA SUPERVISORS		
Area 1	Judi Navarro	233-7613
Area 2	Brenda Meredith	233-7321
Area 3	Brenda Buroker	233-7080
Area 4	Brenda Meredith	233-7321
Area 5	Karen Powers	233-7753
Area 6	Pat Nicolaou	233-7441
Life Safety Code	Rick Powers	233-7471
ICF/MR North	Chris Greeney	233-7894
ICF/MR South	Steve Corya	233-7561

Web Sites of Note

Certified Nurse Aide Registry

<http://www.in.gov/isdh/regsvcs/acc/certhha/index.htm>

CNAs with Verified Findings

<http://www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm>

MDS Bulletins

<http://www.in.gov/isdh/regsvcs/acc/oasis/>

MDS Web Site

<http://www.cms.hhs.gov/MinimumDataSets20/>

Nurse Aide Training Guide

<http://www.in.gov/isdh/regsvcs/ltc/naguide/index.htm>

Nurse Aide Training Sites

<http://www.in.gov/isdh/regsvcs/ltc/natdir/index.htm>

Consumer Guide to Nursing Homes

<http://www.in.gov/isdh/regsvcs/ltc/profile/index.htm>

Nursing Home Compare (CMS)

<http://www.medicare.gov/nhcompare/home.asp>

Report Cards

<http://www.in.gov/isdh/regsvcs/ltc/repcard/index.htm>

Questions About Healthcare

<http://www.in.gov/isdh/regsvcs/ltc/questions/index.htm>

Reporting a Complaint

<http://www.in.gov/isdh/regsvcs/ltc/complaints/index.htm>

Access Indiana

<http://www.in.gov/>

Indiana Secretary of State

<http://www.in.gov/sos/>

Family and Social Services Administration- Aging:

<http://www.in.gov/fssa/da/index.htm>

Indiana Medicaid

<http://www.indianamedicaid.com/ihcp/index.asp>

Indiana State Police

<http://www.in.gov/isp/>

Indiana Health Care Providers:

<http://www.in.gov/isdh/regsvcs/providers/index.htm>

Indiana State Department of Health Web Page

<http://www.in.gov/isdh/>

Health Care Regulatory Services Commission

<http://www.in.gov/isdh/regsvcs/>

Laws, Rules, and Regulations

<http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm>

State Operations Manual

<http://www.cms.hhs.gov/manuals/IOM/list.asp>

Centers for Medicaid and Medicare Services (CMS)

<http://www.cms.hhs.gov/>

US Government Printing Office

<http://www.gpo.gov/>

ICF/MR Facility Directory

<http://www.in.gov/isdh/regsvcs/ltc/icfmrdir/index.htm>

Long Term Care Facilities Directory

<http://www.in.gov/isdh/regsvcs/ltc/directory/>

Non-Cert. Comp. Care Facility Dir.

<http://www.in.gov/isdh/regsvcs/ltc/nccdir/index.htm>

Residential Care Facilities Directory

<http://www.in.gov/isdh/regsvcs/ltc/resdir/index.htm>

Retail Food Establishment Sanitation

<http://www.in.gov/isdh/regsvcs/foodprot/retail.htm>

AdminaStar Federal

<http://www.adminastar.com>

TB Skin Testing Course

http://www.in.gov/isdh/programs/tb/tb_train.htm

How to read a survey

<http://www.in.gov/isdh/regsvcs/ltc/readsurvey/index.htm>

State Forms Online PDF Catalog

<http://www.state.in.us/icpr/webfile/formsdiv/index.html>

LTC Newsletters

<http://www.in.gov/isdh/regsvcs/acc/newsletter/index.htm>

MDS Coordinators, Take Note!

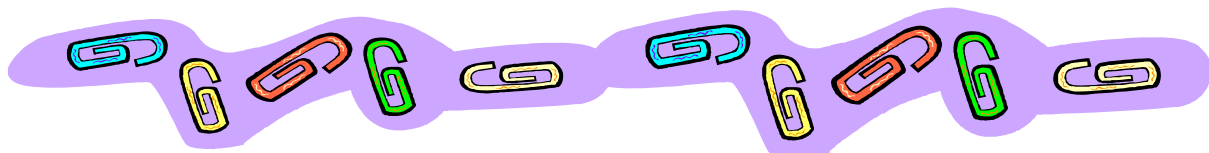


Dave 2 MDS Tip sheet: https://32.71.31.54:81/CMS/DAVE_TipSheet_SectionK5_v6_2.pdf

MDS page: <http://32.71.31.54/>

Infection Control

Quick Facts, educational health handouts including MRSA, Norovirus and hand washing are available at: http://www.in.gov/isdh/healthinfo/quick_facts.htm



Mitchell E. Daniels, Jr.
Governor

Judith A. Monroe, M.D.
State Health Commissioner



Indiana State Department of Health

An Equal Opportunity Employer

December 3, 2007

To Long Term Care Facilities, Home Health Agencies, Hospices, and Hospitals:

The process of checking the registration/certification status of an aide and the process for renewal of registration/certification for certified nurse aides, home health aides, and qualified medication aides will change very soon. This letter is to inform you of the implementation of the new methods of checking the Indiana State Department of Health Aide Registry (Registry) and the process for renewal of an aide on the Registry. Please share this information with your certified nurse aides, qualified medication aides, and home health aides.

Beginning **January 14, 2008**, the Registry will be maintained by the same Indiana Professional Licensing Agency licensing system that is used for physician and nursing licensing. The Indiana State Department of Health, however, will continue to administer the Registry.

The Registry was developed to provide information security and the appropriate access by the certified nurse aide, qualified medication aide, home health aide, and the facility or agency which employs or wishes to employ the aide.

Checking the registration/certification status of an aide

The new Registry will allow anyone to check a registration/certification status for no charge. Only the name of the aide will be necessary for checking the Registry. Beginning January 14, 2008 check the status of an aide by going to <https://extranet.in.gov/WebLookup/Search.aspx>.

Renewal of a registration/certification

The major change in the process of registration/certification is that the individual aide will now be responsible to renew their registration or certification. Facilities or agencies that employ aides may no longer submit renewal information by disk or email as of **December 15, 2007**. We recognize that there will be some certified nurse aides whose certification will expire after December 15, 2007 and before the new Registry is operating. Those certified nurse aides whose certification expires between December 15, 2007 and March 30, 2008 will be extended to an expiration date of March 31, 2008. Indiana State Department of Health surveyors have been notified of this occurrence.

After the Registry is operating, each aide will receive a renewal form and reminder approximately 60 days before expiration of their registration/certification. The renewal form will include the aide's user ID and password for the online Registry.

Renewals for aides may be accomplished in one (1) of three (3) ways:

1. The aide may go online to <https://extranet.in.gov/mylicense/Login.aspx> and renew their own registration/certification. The aide will need the aide ID and password provided on the renewal notice reminder. Online renewals for certified nurse aides and home health aides will be reflected on the Registry within one to two days. Qualified medication aide's renewals will be reflected on the Registry after the Indiana State Department of Health has received the appropriate in-service documentation.
2. The health facility or agency that employs an aide goes online to <https://extranet.in.gov/mylicense/Login.aspx> to renew their certified nurse aides or home health aides. To renew for the aide, the health facility or agency will need the aide ID and password provided to the aide in the renewal notice.
3. The aide or facility or agency that employs the aide may submit a completed paper renewal form to the Indiana State Department of Health Nurse Aide Registry. The Indiana State Department of Health will then renew the registration/certification and update the Registry. Paper renewal requires a longer time period from receipt of the completed form to posting of the renewal on the Registry.

Certified Nurse Aide, Home Health Aide, Qualified Medication Aide

The home health aide will now have to renew their registration every two years. If the home health aide is not also a certified nurse aide, their expiration date will be two years from January 14, 2008. If a home health aide is also a certified nurse aide, their home health aide and certified nurse aide registration/certification will expire at the same time.

The qualified medication aide's renewal fee continues to be \$10. If the online renewal method is chosen there will be a processing fee of \$3.77 for a total of \$13.77. If the online renewal option is chosen, the certification will not be effective until a copy of the in-service documentation is received and approved by the ISDH. The Registry will then show the new expiration date for the qualified medication aide.

While the burden is on the aide to renew their registration/certification, the facility or agency employing the aide must still comply with their respective legal requirements to employ only those aides who are appropriately registered or certified.

If there are any questions regarding renewing aide registration/certification or checking the Registry for aide information, please contact Darlene Jones at (317) 233-7351 or dkjones@isdh.in.gov.

Sincerely,



Terry Whitson
Assistant Commissioner
Health Care Regulatory Services
Indiana State Department of Health

PLAN OF CORRECTION GUIDANCE

The Plan of Correction must contain the following for each tag cited on the CMS-2567-L:

1. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency.
2. Describe how the facility reviewed **all** residents in the facility who could be affected by the same deficient practice, and state what actions the facility took to correct the deficient practice for any resident the facility identified as being affected

For example:

- If the deficient practice is related to falls, you would need to review the fall risk for all residents
- If the deficient practice is related to pressure sores, you would need to complete a skin assessment for all residents at risk for pressure sores or who have pressure sores
- If related to MDS, you would need to review all MDSs

3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.

For example:

- Reviewed P&Ps
- Instituted new P&Ps
- Inservice
- Instituted a new form
- Broadened use of 24-hour report, etc.

4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include:

Who is responsible

- The system by which the responsible person(s) will monitor
- Frequency of monitoring. If “random” monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc.

Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped.

5. For each tag, include the date by which the systemic changes will be completed. Said date must be **after** the exit date of the survey.
6. Administrator or designee must sign and date the 1st page of Plan of Correction.

Updated list of new CNA's with verified findings from 04/03/2007 to 12/04/2007

A complete listing can be found at <http://www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm>.

AARON, TERESS L	CLEMONS, LINDA C	HANSFORD, SANDRA K
ABRAM, WILLIAM	CLEVENGER, TARA	HARNESS, MICHELLE
ABSTON, ANGELA M	CLONCS, JOCELYN	HARPER, HEATHER M
AGNEW, LYNETTA C	CLONTS, DARNITA	HATTER, VICKIE L
ALLEN, CHRISTA D	COFFENBERRY, EMMA J	HENSLEY, NORMAN T
ALLEN, LYDIA J	COLE, AISHA L	HILL, PORTIA
ASBURY, HOPE	COLLINS, TERESA	HILLIARD, DANIELA T
ASHBY, QUINTIL J	COMER, FAUNA E	HILLMAN, ANGELA K
AURILUS, RISSA	COOK, CHERYL	HINTON, DONNA E
BACON, VERONDA M	COOKSEY, BILLIE J	HOLLOWAY, ERICA
BAGBY, RICHELLE Y	COPPOCK, KATHY	HOOTEN, MICHAEL
BAKER, SHAMBERLEY	COSTELLO, TERRI L	HOSKINS, ELLISA I
BALDWIN, ASHANTI F	COULTER, BETSY J	HOSTETLER, SHANNA
BALL, LORETTA	COX, TAWNDA S	HOTZ, KAREN L
BANKS, RIKITA D	CRAFT, MISTY D	HOUSER, BARBARA
BARKER, KEESHA	DANCY, ALAN W	HUGHES, DEBORAH K
BASKIN, DELICIA A	DAWS, CARLA S	HUGHES, LACY J
BAUGH, BILLIE J	DEAN, SHARON E	HUTCHINS, CAROL
BELCHER, WILLIAM D	DICKERSON, MYLES A	HUTCHISON, TANYA
BENNETT, LISA G	DIERINGER, SARA	HYATT, MINDY
BERNAL, LINDSAY M	DRAKE, TIFFANY	JENKINS, SHELIA M
BICKEL, DARLENE	DRUMMER, DANIELLE	JINADU, OKE I
BISHOP, JULIE A	DUFFY, SOPHIA	JOHNSON, DEVIN L
BOHNERT, KRISTINA	DUNN, AMBER	JOHNSON, LARRY D
BOLDEN, DEMETRIUS	EASTERDAY, HEATHER S	JOHNSON, LISA
BORNE, CANDY	EDMONDSON, MAKEDA J	JONES, GABRIELLE
BOTTOMS, ANNETTE S	EDMONDSON, MOLLY S	JONES, KERAH
BOWENS, JA VON R	ELKINS, CASANDRA	JONES, LANA K
BOWERS, CAROL A	ELPERS, APRIL M	JORDAN, DOROTHEA
BOWLING, JANUS	FARRIS, AMANDA R	KELLER, DEANNA L
BOYD, KHAWANDA K	FAULK, GABRIELLE L	KENDALL, YVONNE M
BRADY-KRANTZ, AMY A	FOLEY, DAWN	KENNY, DAVID S
BRIDGEMAN, AMY L	FORD, YEVETTE	KESSNER, BRENN A D
BRISTOW, JENNIFER	FRANKLIN, TARA	KING, MELISSA A
BROCK, JACQUELINE K	FRISQUE, ASHLEY	KIRK, JANICE M
BROOKS, SONDR A L	FULKERSON, BONNIE J	KLEINHEN, JILL R
BROOKS, STEPHANIE	FULTZ, JESSICA M	KOEBKE, KENNETH A
BROWN, JEAN M	GAINES, FAITH L	LACY, TORIA L
BRYCE, SHARON N	GAMMON, CLIFFORD	LAISURE, SHIRLEY
BURKE, PATRICE C	GANSHORN, TRACEY J	LANCE, SCOTT A
BUSSARD, ZANE V	GIBSON, TONYA	LANGER, SUSAN
BUTLER, DONNA	GLASS, PATRICIA A	LAPCZYNSKI, JUANITA K
BYRD, DONNA E	GOHEEN, DONNA P	LETNER, CATERINE
CADE, TIANA L	GRAY, LATOSHIA R	LEWIS, LADONNA
CARADA, HEATHER	GREEN, KENNETH	LIPE, TIMOTHY R
CARLIN, KIM	HACKNEY, ANGELA F	LONBERGER, DEVONNA M
CASH, SHARON L	HAGERTY, RHONDA	LOUDEN, CARRIE L
CAUDILL, CHRYSTAL	HALL, CAROL Y	LOWERY, CANDY
CHAFFORD, BRANDY	HAMBY, JANICE A	LYNN, MENDELLA J
CHAPMAN, ERIKKA	HAMILTON, DONNA	MANNA, CYNTHIA M
CHAPMAN, VERONICA K	HANKINS, PEGGY D	MANNION, MARLA A
CHINN, REBECCA	HANKINS, TIONA R	MATANO, RUTHIE L

Updated list of new CNA's with verified findings from 04/03/2007 to 12/04/2007

A complete listing can be found at <http://www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm>.

MATHEWS, SHANNON L	SMTIH, PAULA M	WYATT, JENNIFER
MATTHIE, MICHELLE	SNYDER, LYNN M	YAKOVICH, DONNA S
MAXWELL, JAMESE	SOUDER, SHANNON K	YELDIG, BONNIE -
MCBRIDE, BRADLEY D	SPIGGLE, MELANIE K	
MCCRAY, VERMELL L	STACY, SHARON N	
MINNIS, RACHEL M	STANLEY, PENNY	
MONTGOMERY JR, CHARLES	STARK, BRANDY	
MORROW, MICHELLE	STARNES, LORENE L	
MOYER, SANDRA	STONE, GLORIA	
MUMFORD, MEDINA N	SWARTZ, BRACIE	
NOENS, EMILY	SWEATT, MELINDA S	
OLIVER, DEANNE R	SWEENEY, BILL J	
OWENS, PAMELA K	TAYLOR, LISA	
PACE, NAQUITA	TAYLOR, SHERYL A	
PALMER, NICHOLE M	THOMAS, MARGARET J	
PARKER, AMBER N	THOMAS-GRETENCORD, AMIE	
PATTERSON, DONISHA	TIPTON, TANDI S	
PEREZ, FREDDIE	TRUXAL, SARA L	
PERRY, CYNTHIA	TUCKER, KENDRA D	
PETERSON, NATALIE	UPDEGRAFF, GAYLE A	
PHILPOT, KAREN	VANOSDAL, AMANDA	
PIERSON, DELISSA L	VILLEGAS, DAMON R	
PIONKE, SUSAN M	WADE, KAREN S	
RANKINS, TAVARES	WALDON, MARCIA	
REGAN, DAWN M	WALKER, DEBRA C	
REINHARDT, MARY K	WALKER, THERESE M	
REVELL, STEPHEN W	WALTERS, AMY	
RHEA, DEBORAH A	WALTON, BRIGITTE N	
RICE, BRANDY M	WASH, BENJAMIN S	
ROBERTSON, ROBBIN L	WASHINGTON, MONICA	
ROBINSON, MICHELLE	WATSON, TY'ASHA O	
ROGERS, BOBBIE R	WAYNICK, CHARITY	
ROSSOK, JESSICA D	WELDON, KATRINA M	
RUCKER, ANGELA L	WELDON, MICHELLE R	
SAMUELS, SHAUMBRIA	WESTBROOK, NIKEETA J	
SANDERS, ALICIA M	WHITE, REBECCA A	
SATERFIELD, RONALD	WHITELY, SUE	
SCHAFER, THERESA J	WIGGINS, EVELYN	
SCHWERING, MELINDA S	WILIAMS, CHRISTINE N	
SCOTT, BEATRICE	WILKERSON, ROBIN L	
SEEHAUSEN, ROSEMARIE	WILLIAMS, CAROL J	
SESKE, TONIA	WILLIAMS, FELISA M	
SEYMOUR, TIKKI M	WILLIAMS, VANELLA -	
SHAW, HEATHER S	WILLIS, JAIME L	
SHAW, SANDRA L	WILSON, WENDY	
SIDEBOTTOM, SEAIRRA S	WINKLER, VERNA L	
SIMMON, MARY	WINLAND, BETHAGENE	
SMITH, ALICIA	WIREMAN, TERESA A	
SMITH, CHARLES D	WOLIVER, ANGELA J	
SMITH, LANAE D	WOODS, AMBER D	
SMITH, TOSHA L	WORLEY, JEFFREY T	
SMITH JR, FRED J	WRIGHT, DEBRA R	



TIPS and TOOLS

NHQI A monthly publication of the Nursing Home Quality Initiative

Restraint Reduction and Fall Prevention:

They do go hand-in-hand

The following overview is Part 1 of 2 of Diana Waugh's presentation "Let Freedom Ring—A Dynamic Duo of Topics Focusing on Freedom from Restraints and Pain" presented in November 2006 for the Indiana Medicare Quality Improvement Organization's NHQI. Diana Waugh, RN, BSN, Waugh Consulting, is a long-term care consultant.

Setting a goal of preventing all falls and injuries is **NOT** realistic. Annually, 35% to 40% of community dwelling, healthy adults over age 65 fall. These rates are higher after age 75 and are almost 3 times higher in nursing homes and hospitals. Fifty percent of those who fall do so repeatedly. Over age 65, injury is the fifth leading cause of death and most injuries are related to falls. Forty percent of nursing home admissions are, at least in part, related to falls.

Restraints **DO NOT** prevent falls, contrary to popular belief. Research has shown that restraints are not associated with a significantly lower risk of falls or fall-related injuries. Several studies have shown that restraints significantly increase the number of falls and injuries.

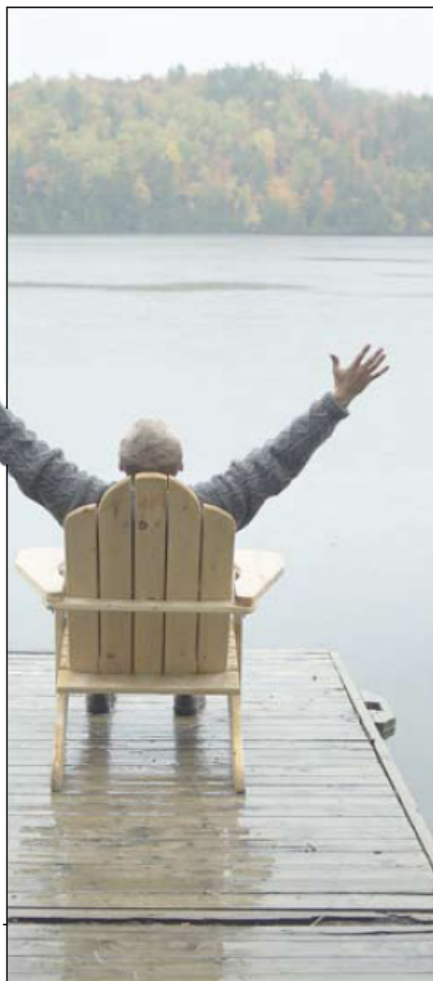
Fall Prevention—Strategies for Implementing

1. KNOW YOUR RESIDENTS. To prevent falls and successfully intervene, you must know which residents are at risk and what factors put them at risk.

Example: Mrs. Speers, her balance impaired, can get out of a chair independently, but within 10 to 15 seconds, she is likely to lose her balance. With that knowledge and awareness, staff can offer assistance to help meet her needs.

The goal is to know residents well, determine the residents' motivation for their behavior, and help them successfully meet their needs. Key to this level of knowledge are **CONSISTENT ASSIGNMENTS**—the same caregivers consistently caring for the same residents (80% of their shifts).

Knowing your residents means to "know" their stories, three things that make them laugh, what they like to see, smell, touch, taste, and feel, and what triggers unhappy or unpleasant feelings. Preadmission home visits are helpful to see where and how future residents live to help plan a successful transition. Bringing items they see and touch daily can help them feel more "at home."



2. EVERYONE HAS A PART. Educating all staff is essential in establishing a successful fall prevention plan. This includes staff knowing residents by name and knowing enough about them for positive interaction.

Example: Mr. Taylor likes to get up out of his favorite glider rocker and needs assistance to walk safely. The housekeeper observes him getting up and says, "Mr. Taylor, before you go, would you have time to share with me..." Diana Waugh breaks down, into parts, the use of this powerful "magic" sentence explaining its rewarding benefits.

1. Use the resident's name...this catches the resident's attention and lets the resident know that he or she is important.
2. "Before you go"... this lets the resident know that you recognize his right to go, to do what it is he needs, or wants to do.
3. "Would you have time?"...this lets the resident know that you value his or her time.
4. "To share with me"...this is asking the resident for something.
5. An individual story, an event, a person, etc., involves the resident in an interaction, helps focus attention on something pleasant, and provides staff the opportunity to implement the appropriate intervention to meet his or her need.

3. ELIMINATE THE WORDS "NO" AND "STOP" Shouting or even calling out "no" or "stop" evokes a negative connotation that the resident is doing something wrong. Is it "wrong" to want to get up? Is it "wrong" to have to go to the bathroom? No, and most of us unknowingly use those words multiple times a day.

4. FIND CREATIVE WAYS FOR RESIDENTS TO SUMMON HELP. Residents sitting away from the call light system are unable to summon help without calling out. Finding an alternative method to keep the environment calm and provide residents with a sense of security and control is essential. A mechanism, like a small bell or ringer, may make the difference between someone shouting or calling out "help me, help me" continuously.

5. ELIMINATE THE TERMS "ALLOW THE RESIDENT" OR "LET THE RESIDENT." The terms "allow" or "let" are not person-centered and imply that staff have control. Residents have the right to make decisions about their lives, to have control and choices in what they do.

6. CONSIDER TEACHING RESIDENTS AT RISK FOR FALLS HOW TO FALL SAFELY. In many rehabilitation programs, individuals are taught how to fall to prevent or minimize injury. This may be a life saving intervention, especially for those individuals who will be returning to their homes and need to know how to fall and how to get up by themselves.

7. ELIMINATE WHEELCHAIRS WHENEVER POSSIBLE. While wheelchairs provide fast and convenient transportation, being restricted to a chair gives residents a sense of illness rather than wellbeing. Wheelchairs promote "dependence" and decrease normal physical function. Residents lose strength, balance, and a sense of self. Rising from a wheelchair is not a "normal" function. It presents a definite hazard if an individual gets up without remembering to lock the wheels, and attempts to stand up on the foot pedals instead of the floor.

Use restorative programs and/or activities to increase strength, balance, and endurance. Set a goal to increase the amount of time residents spend outside of wheelchairs. Teach residents independent transfer from the wheelchair to other surfaces, as much as possible. Some residents are so "trained" and "socialized" to a wheelchair that change may not be possible. Start with newer residents and try to break the wheelchair cycle.

Strategies for eliminating restraints will be addressed in the next issue of Tips and Tools. For additional information, please visit the Health Care Excel Web site (www.hce.org) under "Past Events" for recorded teleconferences and handouts. Also, visit www.medqic.org under "Nursing Homes."



TIPS and TOOLS

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Restraint Reduction and Fall Prevention:

They do go hand-in-hand

The following overview is Part 2 of Diana Waugh's presentation "Let Freedom Ring—A Dynamic Duo of Topics Focusing on Freedom from Restraints and Pain" presented in November 2006 for the Indiana Medicare Quality Improvement Organization's NHQI. Diana Waugh, RN, BSN, Waugh Consulting, is a long-term care consultant. The March 2007 issue of Tips and Tools recounted the highlights of Diana Waugh's presentation on preventing falls. This issue focuses on tips for reducing and eliminating restraints on an organizational scale.

Strategies for eliminating restraints

Eliminating restraints is not just a "pie in the sky" dream, but rather a concrete goal that can be achieved in long-term care. Reducing restraints can only be accomplished through vision, hard work, and the persistent belief that it can be done.

For individuals who have been in health care for many years, the belief that restraints are not in the best interest of residents and the nursing home, and have more negative effects than positive outcomes, is rather hard to accept. Restraints were an accepted common practice in the past; however, times have changed. Research advances, human rights and best practices continue to evolve, and restraining residents is no longer accepted as "best practice."

Restraints are dangerous. They can and do kill many nursing home residents every year. Because restraints are so dangerous, the order for a restraint can only be in place for 24 hours in other health care settings. (The patient must then be reassessed and a new order written.) A physician must assess the patient to order the restraint and document medical necessity.

During Indiana QIO nursing home provider meetings in November 2006, long-term care consultant Diana Waugh suggested that for each resident restrained in your home, answer the following question. "Can you support and defend why this resident is restrained to the Supreme Court?" If you can't, then evaluate why the resident is restrained and start looking at what can be done in place of the restraint.

The dialog in a nursing home begins with a vision and mission that restraints will not be used, and with the

Restraint Myths

Restraint myths abound in long-term care. Some of these myths include the following.

- Restraints prevent falls and they prevent injury.
- It is our moral responsibility to safeguard residents from harm by using restraints.
- Failure to restrain puts the facility at legal risk.
- Residents don't mind being restrained; it makes them feel secure.
- Restraints must be used because of inadequate staffing.
- We don't know what else to do.

knowledge and wisdom that nursing homes cannot guarantee that residents won't fall. In fact, it's very likely they will. Next, leadership makes a decision that on a stated date restraints will no longer be used. Staff education should center on the dangers of restraints, the alternatives, the plan for reduction, and eventually elimination.

Nursing homes' goals for fall prevention and minimizing injury should involve residents and families in partnership with an organization-wide falls prevention team. As experts and leaders in long-term care, nursing homes can spearhead community education on the importance of eliminating restraints. An informative brochure, "What You Need to Know about Choice, Falls, and Restraints in Nursing Homes," is available on the Health Care Excel Web site at <http://www.hce.org/Medicare/NHQI/QIORestraintsBrochure.pdf>.

For more information from the Agency for Healthcare Research and Quality, on studies supporting the reduction and elimination of physical restraints, go to <http://www.ahrq.gov/clinic/ptsafety/chap26b.htm>.

Source: Neville Strumpf, Mary Shelkey, "Module 14: Physical Restraint Reduction for Older Adults" The John Hartford Foundation, Institute for Geriatric Nursing. <http://www.hartfordign.org/guides/Module14PhysicalRestraintReductionforOlderAdults.doc>. Accessed 3/28/07

This material was prepared by Health Care Excel, the Medicare Quality Improvement Organization for Indiana, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. BSOW-IN-NH-07-31 05/02/2007

Making the Right Choice

Information for People Living in Nursing Homes and Their Families



What You Need To Know About Choice, Falls, and Restraints in Nursing Homes



Medicare Quality Improvement
Organization for Indiana

What Is A Physical Restraint?

A restraint is anything used to keep a person from moving around or moving a part of the body, like the arms or hands.

Physical Restraints Can Include:

- Special chairs, such as geriatric chairs or chairs with trays
- Anything that keeps a person from getting out of a chair or bed, such as: trays, bars, belts, vests, lap cushions, side rails, or seat belts
- Wrist or ankle bindings, mittens

A restraint is like any other medical treatment. You need to know what medical symptoms are being treated and the many risks related to restraint use. They are not harmless safety devices as is often thought. If there is not a medical reason for the restraint, it should not be used. Restraints must never be used to punish a person or to make a person easier to handle. A physician order is needed before any restraint can be used.



Information provided by Stratis Health. Edited by Health Care Excel, the Medicare Quality Improvement Organization for Indiana, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 85OW-JN-NH-07-02 01/05/2007

Myths About Restraints:

Myth: Restraints prevent falls and injuries.

Fact: Studies show restraints do not prevent falls and often cause more injuries and even deaths.

Myth: It is a nursing home's moral responsibility to keep people safe and prevent all falls.

Fact: Nursing homes are responsible for caring for people and helping them stay as healthy and happy as possible. There are no absolute ways to ensure safety. Unless you can find the reason for the falls and fix them, it is unrealistic to think any set of interventions can prevent all falls.

Myth: Residents do not mind being restrained. It makes them feel secure.

Fact: No one likes to feel helpless, trapped, or demeaned. A restraint can cause your loved one to become angry, depressed, confused, agitated, or withdrawn. Few of us would ever choose restraint use for ourselves.

Myth: There are not any other options to protect my loved one.

Fact: Rarely is this true. Most people that live in nursing homes are better cared for without using restraints, and more effective safety methods can be substituted for restraints.

Do Restraints Have Risks?

When a person has his or her freedom limited with restraints, it can cause health problems or serious complications, such as:

- **Death**
- **Falls**
- **Constipation**
- **Poor nutrition**
- **Anxiety**
- **Loss of appetite**
- **Loss of dignity**
- **Dehydration (not getting enough to drink)**
- **Bladder infections (cannot get to bathroom)**
- **Incontinence (lack of bladder control)**
- **Pneumonia**
- **Bed sores**
- **Bruises**
- **Weak bones and muscles**
- **Stiff joints**
- **Lack of sleep**



What can I do as a family member?

- Recognize that risks are a part of life and few of us would ever find quality of life having our movements restricted by devices. Ask yourself, "Would I want to be restrained?"
- Talk to the staff about your loved one's habits and routines. Share information about past interests, hobbies, previous occupation, likes and dislikes, sleep and behavior patterns. These things help the team create a plan of care that meets the needs of your loved one and lessens the need for restraints.
- Bring items from home that provide comfort for your loved one, especially when he or she is getting familiar new surroundings. This might include a favorite chair or blanket, pictures, books, or special foods. Keep personal items within reach.
- Work with the nursing home staff as a team member. Your concern, interest, and input are invaluable in providing the best possible care for your loved one.
- Spend time with your loved one if and when possible. You can be an extra pair of eyes and hands. You also provide the relationship that maintains his or her sense of identity.
- Know the risks of restraints.

If your loved one is in restraints:

- Ask to see the total safety plan developed for your loved one and discuss any questions and/or concerns you may have.
- Ask about the different things that were tried before restraints were used.
- Ask what the risks are related to the restraint use and how they are being addressed.
- Ask the staff to identify how the use of restraints is a benefit to the person.
- Ask the physician and staff about their plan for decreasing restraint use. How long will it be used? When will it be removed?

A word about siderails....

Although some people think that siderails are safety devices, there is no evidence to support that claim. In fact, evidence shows that siderails are a danger. Alternatives to siderail use may be to lower the bed or change the environment in some other way.

Maintaining mobility, choice, and safety

It's important to care for people in ways that support choice and mobility as well as address their safety needs. The less mobile people are, the more likely they are to be injured when and if they do fall. The key to improving safety is individualizing care. Safety plans for frail at-risk elders need to be individualized. They need to address internal risk factors like fatigue, weakness, pain, and osteoporosis, as well as environmental risk factors such as inappropriate wheelchairs, poor lighting, and shoes that don't fit well.

Each person's safety plan should be unique and based on a complete assessment.



How can nursing homes improve safety and mobility?

- + Develop a plan for safety and mobility based on a complete assessment of the person.
- + Ask the resident, family members, and direct care staff to be a part of care planning conferences.
- + Assess for and treat pain.
- + Be sure that all staff know the people they are caring for and honor their wishes, habits, and needs.
- + Create and support a daily routine that meets unique needs and wishes of the individual.
- + Ask for a physical therapy or occupational therapy assessment for mobility and the best restorative and safety devices (walkers, wheelchairs, grab bars, bed height, shoes).
- + Know about the risks of restraints.

- + Include the person in a care program that focus on maintaining mobility.
- + Include residents and invite them to participate in regular exercise programs.

Remember...

Everyone deserves as much freedom and dignity as possible. Restraints should only be used as a very last resort. If people are able to move around on their own, it helps them:

- + Keep their dignity
- + Feel more content and independent
- + Dress, walk, and feed themselves
- + Interact with others and the world around them
- + Keep their muscles working and keep their strength

To compare local nursing homes use of restraints, visit <http://www.medicare.gov/then/select/CompareNursingHomesInYourArea>.

Please distribute to nursing home Administrator or DON



Join the FAST LANE – Local Area Network for Excellence

We're looking for YOUR help to get your State's LANE to the TOP of the Leaders Board!*

*All nursing homes that sign up by November 21 will receive a special recognition at the **LANE Interchange conference***

Advancing Excellence Leaders Board *					
State Lane	#1 Overall	Most Improved	Platinum	Gold	Silver
Your State LANE	X		X		
State A LANE				X	
State B LANE			X		
State C LANE		X			X

* Leaders Board will be posted on the Advancing Excellence Web Site!

Campaign Goals

1. Reduce high-risk pressure ulcers
2. Reduce use of physical restraints
3. Improve pain management in long stay residents
4. Improve pain management in short stay residents
5. Set targets for clinical quality improvement
6. Assess resident and family satisfaction
7. Increase staff retention
8. Improve consistent assignment of staff

What You Need to Register

1. Facility 6 digit Medicare Provider Number
_____ N/A if not Medicare
2. Facility key contact information
3. Facility second contact information
4. User name and logon for web site
5. Know your facility performance improvement goals and be ready to select similar campaign goals.

It's Easy to Register

1. Log on to: www.nhqualitycampaign.org
2. Click on "Campaign Goals" and choose 3 goals consistent with your current facility goals
3. Click on "How to Get Involved" on Home page
4. Click on "Providers" and read the text
5. Click on "Register to Participate" and read text to get more information on goals
6. Click on "Proceed to Registration Form"

For Help

Click on this link at www.nhqualitycampaign.org





A campaign to improve quality of life for residents & staff

September 25, 2007

Dear Advancing Excellence Campaign LANE Convener,

The Recruitment Committee of the Advancing Excellence in America's Nursing Homes Campaign is excited to announce to you the **50 Leaders Promotion**. Our recent **Trailblazer Promotion** was a huge success and has brought the campaign close to its first year goal of enrolling 6,000 nursing homes by September of 2007. This new campaign will start on September 25 and end on November 21, 2007.

The Advancing Excellence Campaign recruitment milestone is to enroll 8,000 nursing homes, or a minimum of 50% of all nursing homes in America by the end of 2007. Can you imagine the positive message it would send if we exceed that goal?

We believe we can achieve this goal, and to do this, we must enroll more than 50% of all nursing homes in each and every LANE jurisdiction. The goal of the Leaders Promotion is for all jurisdictions or LANEs to become Leaders! (See your state's percentage at "Progress by State" in the box on the right side of our Web site, www.nhqualitycampaign.org.)

The **50 Leaders Promotion** is designed to focus on those jurisdictions that have not achieved participation by at least 50% of the nursing homes in their jurisdiction. The campaign is structured with a variety of recognitions so that every jurisdiction has the opportunity to win in one or more categories. Recognition categories are as listed below:

- Leaders Board – The Advancing Excellence in America's Nursing Homes Campaign Web site will prominently display a list of "Leaders", those states that have achieved a 50% or higher participation (% of state nursing homes enrolled in campaign) level.
- Platinum – LANEs that achieve a 90% or higher participation
- Gold – LANEs that achieve a 75-89% participation
- Silver – LANEs that achieve a 50-74% participation
- Top Ten – LANEs with the top ten highest percentage of participation
- #1 Overall – LANE with the highest percentage participation
- Most improved LANE – LANE with the greatest increase in participation

As you see, we have opportunities for everyone to be a winner in the ***Advancing Excellence Leaders Promotion***. The winners will be announced and recognized on the Advancing Excellence Web site, in press releases, and at the LANE Interchange conference in late November.

All we need now is your help. Tools and resources will be provided to support you in your effort to increase participation in your jurisdiction. In addition we will be structuring forums and mentoring opportunities with campaign staff and volunteers, and jurisdictions with a high recruitment success. Please join us in assuring that your LANE is one of ***50 Leaders in Advancing Excellence!***

Sincerely,

Advancing Excellence Steering Committee

Agency for Healthcare Research and Quality

Alliance for Quality Nursing Home Care

American Academy of Nursing

American Association of Homes and Services for the Aging (AAHSA)

American Association of Nurse Assessment Coordinators (AANAC)

American College of Health Care Administrators (ACHCA)

American Health Care Association (AHCA);

American Medical Directors Association (AMDA)

Association of Health Facility Survey Agencies (AHFSA)

Centers for Medicare & Medicaid Services (CMS) and its contractors, the Quality Improvement Organizations (QIOs) and State Survey Agencies; Foundation of the National Association of Boards of Examiners of Long Term Care Administrators

National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC)

National Association of Health Care Assistants (NAHCA)

National Citizens' Coalition for Nursing Home Reform (NCCNHR)

National Commission for Quality Long-Term Care

National Conference of Gerontological Nurse Practitioners (NCGNP)

National Gerontological Nursing Association (NGNA)

Service Employees International Union (SEIU)

The Commonwealth Fund

The Evangelical Lutheran Good Samaritan Society

The John A. Hartford Foundation's Institute for Geriatric Nursing

Roundtable Questions 2007

Universal Precautions and Patients' Rights form may be accessed at:

<http://www.in.gov/isdh/regsvcs/ltc/facfiles/universalprecautions.pdf>

1. Power Strips

A facility recently reported conflicting directions from the Life Safety Code Inspector versus the State Fire Marshall. One stated that it was appropriate to utilize a power strip (in that a facility may have an electric bed as well as various other types of resident appliances requiring multiple outlets), given the power strip is UL rated and tagged appropriately. However, when the State Fire Marshall viewed the same power strips, the facility was instructed that no medical equipment (feeding pumps, oxygen concentrators, electric beds, etc.) could be plugged into such a strip (even though tagged with UL approval). Please clarify the appropriate use of power cords in a resident room.

Response: Power strips may be used at the foot of the bed for TV's etc.; they may not be used at the head of the bed. No medical equipment can be plugged into them, including electric beds. High voltage items or nothing with a 3 prong plug may not be plugged into power strips. This does not apply to the little transformers that are used for things like cell phone chargers.

2. Employee Photos

Many facilities take employee photos at the time of hire. In the event of a resident allegation of abuse, this often assists to expedite the investigation, in that the resident can view photos and may be able to identify the employee involved in the alleged abuse allegation, or it can eliminate an employee as a potential suspect. Although a facility investigation would not solely rest upon the use of such photos, is there any concern or prohibition of this practice from the view of the Indiana State Department of Health?

Response: No, this practice is based on facility policy.

3. LTC Newsletter/Request for Consultant Reports During Entrance Conference

The April 27, 2007 newsletter provided survey checklist forms that will be provided to facility staff at entrance conference. The page identified as information/documentation to be provided to surveyors within 24 hours of the conclusion of the entrance conference, lists "**consultant logs.**"

a.) Facilities are mandated to have a consultant dietitian (if dietitian is not on staff), consultant pharmacist, and social service consultant (if using a social service designee). It is anticipated that these are the consultant logs being referenced. Facilities may choose to have a medical records consultant, nurse consultant, etc.; however, it is anticipated that these are not logs that would be provided, in that they are not required consultant visits. Would you agree?

Response: Yes

b.) Also, please confirm that the intention is that the survey team review consultant "logs" to verify compliance with consultant visits; however the internal reports provided by the consultant to the facility are not necessary to be provided to the survey team.

Response: Pharmacist and dietician reports may be required to determine regulatory compliance. If required, Social Service and Activity consultant verification may be requested.

4. Oxygen tanks

I was contacted by one of our members who has been informed by their contracted respiratory therapy company that filling portable oxygen tanks from a large tank can not be done by a CNA, as they are not allowed to do so "per rule." I am unaware of any such prohibition, if the CNA has been trained to fill the portable oxygen tank. Are there concerns from other areas (i.e., life safety)?

Response: The C.N.A. is allowed to fill portable oxygen tanks if trained and competent. Please note C.N.A.s may not adjust the oxygen flow rate.

5. Provider Survey Questionnaire

A facility has reported that they have had annual survey and two complaint surveys since the implementation of the Survey Questionnaire. When asked by corporate personnel if they had completed the questionnaire following survey, administrative facility staff reported that they had not been provided the questionnaire during any of the three surveys.

Response: The questionnaire may be downloaded at: <http://www.in.gov/isdh/regsvcs/ltc/provsurv/53183.pdf>

6. Dining service

During a recent survey an Administrator was told by a surveyor that all residents' meal trays should come to the main dining room at the same time - even if 2 carts are needed.

The facility practice is to make sure that the residents at the same table are served at the same time. Trays are brought out - one cart at a time - so that there are no trays sitting out for several minutes before they are given to the residents. State Rule requires the facility provide "food at proper the temperature" and "Store, prepare, distribute and serve food under sanitary conditions." There appears to be no basis in the regulation for this strong "suggestion" from them, other than surveyor opinion or preference.

Response: There is no regulation or rule requiring all residents seated at multiple tables to be served at one time.

7. F498 Proficiency of Nurse Aides.

The regulation states:

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

Probes:

Do nurse aides show competency in skills necessary to: maintain or improve the resident's independent functioning, e.g., performing range of motion exercises, assisting the resident to transfer from the bed to a wheelchair, reinforcing appropriate developmental behavior for persons with MR, or psychotherapeutic behavior for persons with MI; observe and describe resident behavior and status and report to charge nurse; follow instructions; carry out appropriate infection control precautions and safety procedures.

Recently, two providers were faulted for not having a "check-off" on their nurse aide orientation specifically for toileting residents at risk for falls during the toileting process. Is it the ISDH expectation that this, in particular, be separately noted on orientation documents?

Response: No

8. RECORD RETENTION: Would you please provide the criteria regarding retention of records by a comprehensive health care facility?

Personnel records: 3 years after termination or separation of employment. Hepatitis B medical records: 30 years after termination of employment.

Patient medical records: 410 IAC 16.2-3.1-50 (b) requires after discharge, a minimum of 1 year in facility and 5 years total. In the case of a minor, until 21 years of age.
405 IAC 1-5-1(b) requires all providers participating in the Indiana Medicaid program maintain records for a period of seven (7) years from the date Medicaid services are provided.

Financial: Consult with an accountant.

In-service: Minimum annual to annual survey for long term care regulatory requirements.

QA records: No requirement; must have proof of meeting requirements at survey. Would advise keeping from survey to survey, at a minimum.

Consultant records: No requirement to keep but must show proof of meeting consultation requirements (when consultation is required). Would advise keeping from survey to survey, at a minimum.

BIPA staffing records: 18 months. Original postings do not have to be kept if electronic storage can reproduce the records.

9. INFORMED CONSENT: If a facility utilizes a consent for influenza vaccination upon which the resident/responsible party gives consent for the vaccination to be administered on an annual basis, and there is a physician's order on the recap for the annual vaccination, is a further (i.e., annual) consent needed?

Note: In regard to an annual requirement of facility action, the interpretive guidance of F334 states as an objective under the investigative protocol: *"To determine if education regarding the benefits and potential side effects of immunization(s) was provided to the resident or legal representative each time a vaccine was offered."*

Also, Indiana Code at IC 16-28-14-2, obtaining informed consent states:

"(b) A health facility shall attempt to obtain the consent required under subsection (a):

(1) upon the patient's admission, if the patient's admission occurs after June 30, 1999; or

(2) before an immunization is administered, if the patient's admission occurred before July 1, 1999."

Note: does not state "upon admission and annually thereafter."

Response: Annual education of the client is required. Informed consent may be a one time occurrence.

10. RN coverage: According to F354, 483.30 (b) The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Some surveyors are still telling facilities that the director of nursing may NOT fill this component. Although this has been clarified in previous Roundtable documents, would you please reconfirm that any registered nurse, e.g., MDS nurse, infection control nurse, Director of Nursing, is permitted to meet this criteria for RN coverage?. *Note: This is not to be confused with the prohibition of the DON serving as a charge nurse only when the average daily occupancy of the facility is 60 or fewer residents.*

Response: This is correct; the presence of the Director of Nursing or any other registered nurse fulfills this requirement.

11. Survey Checklist forms/items: The April edition of the ISDH LTC Regulatory Newsletter contained a checklist of items that will be requested by the surveyor at the time of the annual survey. One form states “the following information/documents must be provided to surveyors, if requested.” One of those items is “consultant logs”. Would you please clarify that only if a consultant is required by law is it appropriate to request that log? The *requirement* to utilize consultants is quite limited and any additional use of consultants is not subject to providing verification of that during the survey process.

Response: The department has revised the checklist. Pharmacist and dietician reports may be required to determine regulatory compliance. If required, Social Service and Activity consultant verification may be requested.

12. Telephone Orders: Can a facility nurse accept a telephone order from “staff” at a physician’s office if that person is other than a nurse practitioner or physician assistant?

Response: Nurses may accept telephone orders from a practitioner with prescriptive authority. Division staff is not aware of any standard of practice, rule or regulation allowing a licensed nurse or medical assistant to communicate orders from the practitioner to a nurse. Electronic transmission of practitioner orders would be acceptable with safeguard provisions for privacy and unauthorized use.

410 IAC 16.2-3.1-22 (f) and 42 CFR 483.40 e & f (F390) allows a physician to delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist under specified provisions.

13. QMA Scope of Practice: Is a QMA permitted to transcribe written physician orders onto the Medication Administration Record/Treatment Administration Record?

Response: Transcribing physician orders is not within the scope of practice of a QMA.

14. Magnetic door locks: Would you clarify the expectation for compliance with magnetic door locks?

Response: Magnetic door locks must have the following provisions:

They must be interconnected with the facility's fire alarm system. The doors must unlock with initiation of the fire alarm system and only reset when the alarm is reset. They must be provided with a means to release. This can be a key pad or keyed release to which all staff has a key. If the magnetic door lock is activated with a 15 second delay, a sign must be posted at the door stating such. No more than one of these locking arrangements can be used in any single path of egress (exit way).

Magnetic door locks should only be used in special care units. Other residents need to be able to come and go through these doors. If they are used in a mixed occupancy, then, all staff and responsible residents must know the code. Special care units housing dementia, etc. residents can have the locks without residents knowing the code. Wander Guard type systems can be used without residents knowing the code. Delayed egress locks can be used in any area provided they meet the requirements of the first paragraph.

15. Isolation/Signage

If a resident is in “contact” (or other type) isolation, is there a prohibition of having a precautionary isolation sign on the door if the sign does not divulge the resident’s name, bed/room number or other such identifier? Would it be considered problematic if the resident was in a private room? Staff would receive report on resident status, however, lacking signage, one might be concerned for visitors, volunteers, laundry personnel, etc., who should check with the nurse prior to entry for any specific isolation instructions.

Response: Posting isolation signage is acceptable if the resident or family does not voice a concern regarding the signage. However, posting an isolation sign is not considered best practice.

16. Need Clarification RE: Tuberculin Skin Testing Requirements

In 2005 the American Lung Association of Indiana (ALA-I) established a new requirement for refresher training every three years for basic class (in TB skin testing) attendees. Therefore beginning January 2008, those persons who are certified in TB skin testing **by the ALA-I** will need to renew that certification *if* they want to remain certified by ALA-I. However *there are no legal requirements to utilize the ALA* for your training program.

There are no statutes in the Indiana Code that address specific tuberculin skin test training or certification. However the Indiana State Rules for long term care facilities, 410 IAC 16.2-3.1-14(t) states”....a tuberculin skin test... administered by persons having documentation of training from a department-approved program...” Note that it does not say “certified” nor does it require training from a *specific* program; rather it must be “department approved”.

Should a facility desire to provide independent training in TB skin testing, a program must be approved by ISDH. Facilities may contact Nancy Adams, ISDH, with any questions.

To view the Indiana State Department of Health’s information on Tuberculosis go to <http://www.in.gov/isdh/programs/tb/index.htm>. For specific *TB skin test training requirements* go to <http://www.in.gov/isdh/programs/tb/pdf/TuberculinSkinTestTrainingRequirements.pdf>

(12/13/07)



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-18

DATE: April 20, 2007

TO: State Survey Agency Directors
State Fire Authorities

FROM: Director
Survey and Certification Group

SUBJECT: **Multiple Providers -** Hospitals, Ambulatory Surgical Centers, Nursing Homes, Religious Non-Medical Health Care Institutions, Programs of All-Inclusive Care for the Elderly (PACE) Facilities, Critical Access Hospitals, Intermediate Care Facilities for the Mentally Retarded – Permitted Gaps in Corridor Doors and Doors in Smoke Barriers

Memorandum Summary

- ☐ In a smoke compartment that is **not fully sprinklered**, a gap between the face of a corridor door and the door stop should not exceed **¼-inch**, provided that the door latch mechanism is functioning.
- ☐ In a smoke compartment that is **fully sprinklered**, a gap between the face of a corridor door and the door stop should not exceed **½-inch**, provided that the door latch mechanism is functioning.

The purpose of this memorandum is to clarify requirements for door gaps in the 2000 edition of the Life Safety Code (LSC), National Fire Protection Association (NFPA) 101. This information applies to corridor doors other than those in required enclosures of vertical openings, exits, and hazardous areas. This information does not apply to doors in smoke barriers, which have other requirements.

The majority of existing health care facilities have solid core wood doors in the corridors, particularly doors to resident or patient sleeping rooms. These doors are usually 36” to 44” wide. Wide wood doors such as those used in health care facilities will expand and contract due to changes in temperature and humidity, and over time warp to some degree. It is not practical, particularly on the latch side of the door, to maintain a minimum of a 1/8 inch gap. For example, a 36” to 44” wood door installed during a dry period with a 1/8 inch gap may not close and latch when the humidity is high. A 1/8-inch gap is not sufficient clearance for proper operation of these doors.

The LSC does not specify a minimum gap for corridor doors [of 1/8-inch] and, in addition, the LSC specifically states that compliance with NFPA 80, Standard for Fire Doors and Fire Windows, is not required (18/19.3.6.3.1). Therefore, it is incorrect to apply the 1/8 inch gap restriction (for doors in smoke barriers) to corridor doors that are not part of a smoke barrier. (18/19.3.7.3 and 8.3.4.1/A8.3.4.1)

It has come to our attention that in limited instances a “light test” has been used to determine if the door gap is adequate or too large. (If the surveyor sees light through the door gap, he/she determines that the gap is too large and the provider is cited for a deficiency.) There is no criterion for a light test anywhere in the LSC or in other NFPA Codes and Standards.

The following Questions and Answers reflect the recommendations of the NFPA Health Interpretations Task Force Door Gap Task Group. The following plan view drawing of a door and frame may help clarify this information.

Question 1: Does the Life Safety Code limit the gap between the edge of a corridor door and the door frame to 1/8-inch?

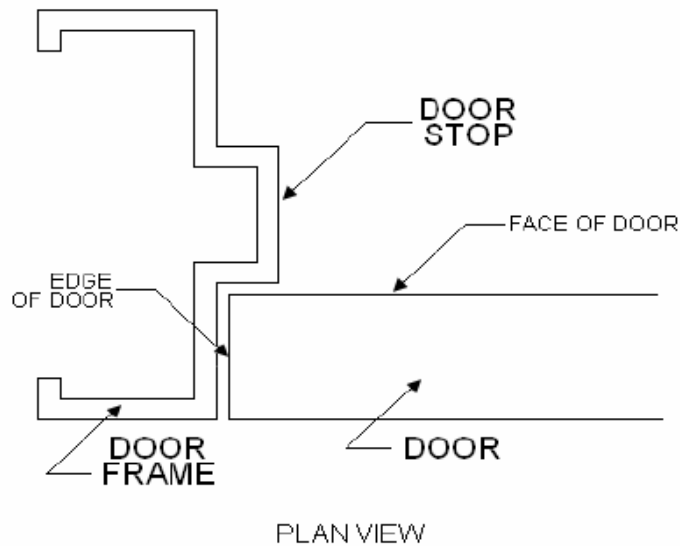
Answer: No. However, because the door stop functions as an astragal, the gap between the edge of a door and the door frame shall not be greater than the depth of the door stop.

Question 2: Does the Life Safety Code limit the gap between the face of the corridor door and the door stop to 1/8-inch?

Answer: No. The LSC does not specify a maximum gap dimension and specifically states that corridor doors are not required to comply with NFPA 80, Standard for Fire Doors and Fire Windows. The Code goes on to state that corridor doors should be relatively smoke tight. Due to the lack of specific dimensions for door gaps and the subjective language in the Code, the following guidance is deemed appropriate. In a smoke compartment that is **not fully sprinklered**, a gap not exceeding **¼-inch** between the face of a corridor door and the door stop should be permitted, provided that the door latch mechanism is functioning. In a smoke compartment that is **fully sprinklered**, a gap not exceeding **½-inch** between the face of a corridor door and the door stop should be permitted, provided that the door latch mechanism is functioning. In a smoke compartment that is not fully sprinklered, to achieve a better fit, the thickness of a 1¾-inch thick corridor door should be permitted to be reduced by removing not more than ¼-inch from the face of the door. In a smoke compartment that is fully sprinklered, the LSC does not impose construction requirements on a corridor door, provided that it resists the passage of smoke. Surveyors determining whether a door is in compliance and fits sufficiently tight in the door frame should refer to the above dimensions.

Question 3: Does the Life Safety Code limit the gap between the meeting edges of the leaves of a two-leaf corridor door to 1/8-inch?

Answer: No. The gap is permitted to exceed 1/8-inch provided that the meeting edges of the leaves are equipped with an astragal, a rabbet, or a bevel.



If you have any questions concerning this memorandum, please contact James Merrill at James.Merrill@cms.hhs.gov

Effective Date: The information contained in this memorandum is current policy and is in effect for all healthcare facilities. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: This information should be shared with all appropriate survey and certification staff, surveyors, their managers and state fire authorities and their staff.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-22

DATE: June 22, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities

Memorandum Summary

- ☐ Clarifies the phrases “remove easily” and “freedom of movement” as related to the physical restraints definition.
- ☐ Further clarifies the meaning of “medical symptom.”

Issue

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing unnecessary physical restraint use in nursing homes and ensuring residents are free of physical restraints unless permitted by regulation. Proper interpretation of the physical restraint definition is necessary in order to understand whether or not nursing homes are accurately assessing devices as physical restraints and meeting the federal requirement for restraint use.

Background

42 C.F.R. 483.13(a) provides that “the resident has the right to be free from any physical or chemical restraints imposed for discipline or convenience, and not required to treat the resident’s medical symptom.” CMS defines “physical restraints” in the State Operations Manual (SOM), Appendix PP as, “any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.” Albeit for different functions, this same definition is used in the SOM, the Resident Assessment Instrument User’s Manual and subsequently the Minimum Data Set (MDS), and in the Quality Measure (QM). Despite using the same definition, the MDS and QM do not capture all physical restraints used because of the MDS’s limited categories and the QM’s calculation methods. Ultimately, surveyors should focus on the appropriate use of all physical restraints, whether or not those restraints are captured on the MDS or in the QM.

Discussion

The following clarifications are meant to be used in conjunction with the definition of physical restraints.

“Freedom of Movement” means any change in place or position for the body or any part of the body that the person is physically able to control.

“Remove Easily” means that the manual method, device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., siderails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the resident’s physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time).

The definition of “medical symptom” has not changed. The information below is a combination of current SOM guidance and some additional clarifications.

“Medical Symptom” is defined as an indication or characteristic of a physical or psychological condition.

Objective findings derived from clinical evaluation and the resident’s subjective symptoms should be considered to determine the presence of a medical symptom. The resident’s subjective symptoms may not be used as the sole basis for using a restraint. In addition, the resident’s medical symptoms should not be viewed in isolation; rather, the symptoms should be viewed in the context of the resident’s condition, circumstances, and environment. Before a resident is restrained, the facility must determine that the resident has a specific medical symptom that cannot be addressed by another, less restrictive intervention and a restraint is required to treat the medical symptom, protect the resident’s safety, and help the resident attain or maintain his or her highest level of physical or psychological well-being.

There must be a link between the restraint use and how it benefits the resident by addressing the medical symptom. Medical symptoms that warrant the use of restraints must be documented in the resident’s medical record, ongoing assessments, and care plans. While there must be a physician’s order reflecting the presence of a medical symptom, CMS will hold the facility ultimately accountable for the appropriateness of that determination. The physician’s order alone is not sufficient to justify restraint use. It is further expected, for residents whose care plans indicate the need for restraints that the facility engages in a systematic and gradual process towards reducing restraints (e.g., gradually increasing the time for ambulation and strengthening activities). This systematic process also applies to recently admitted residents for whom restraints were used in the previous setting.

Physical restraints as an intervention do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom. Restraints may be used, if warranted, as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed. Additionally, physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring himself/herself or others and/or to prevent the resident from interfering with life-sustaining treatment, and no other less restrictive or less risky interventions exist.

Note: Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint. Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent or reduce falls. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.¹

If the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed, unless the resident or legal representative has previously made a valid refusal of the treatment in question. The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 C.F.R. §§483.10(b)(4) and 483.20(k)(2)(ii) respectively. The use of physical restraints should be limited to preventing the resident from interfering with life-sustaining procedures only and not for routine care.

A resident who is injuring himself/herself or is threatening physical harm to others may be restrained in an emergency to safeguard the resident and others. A resident whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of restraints, as long as those restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode.

Conclusion

Although the requirements describe the narrow instances when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Restraints limit mobility and increase the risk for a number of adverse outcomes. Physical restraints certainly do not eliminate falls. In fact in some instances reducing the use of physical restraints may actually decrease the risk of falling.²

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- ¹ American Geriatrics Society, British Geriatrics Society, and American Academy of Orthopaedic Surgeons Panel on Falls Prevention. Guideline for the prevention of falls in older persons. *Journal of the American Geriatrics Society*. 49(5):664-72, 2001 May.
Neufeld RR, Libow LS, Foley WJ, Dunbar JM, Cohen C, Breuer B. Restraint reduction reduces serious injuries among nursing home residents. *J Am Geriatr Soc* 1999;47:1202-1207.
Si M, Neufeld RR, Dunbar J. Removal of bedrails on a short-term nursing home rehabilitation unit. *Gerontologist* 1999;39:611-614.
Hanger HC, Ball MC, Wood LA. An analysis of falls in the hospital: can we do without bedrails? *J Am Geriatr Soc* 1999;47:529-531.
Tinetti ME, Liu YB, Ginter S. Mechanical restraint use and fall related injuries among residents of skilled nursing facilities. *Ann Intern Med* 1992;116:369-374.
Capezuti E, Evans L, Strumpf N, Maislin G. Physical restraint use and falls in nursing home residents. *J Am Geriatr Soc* 1996;44:627-633.
Capezuti E, Strumpf NE, Evans LK, Grisso JA, Maislin G. The relationship between physical restraint removal and falls and injuries among nursing home residents. *J Gerontol A Biol Sci Med Sci* 1998;53:M47-M52.
- ² University of California at San Francisco (UCSF)-Stanford University Evidence-based Practice Center Subchapter 26.2. Interventions that Decrease the Use of Physical Restraints” of the Evidence Report/Technology Assessment, No. 43 entitled, “Making Health Care Safer: A Critical Analysis of Patient Safety Practices.” The full report can be accessed at: <http://www.ahrq.gov/qual/errorsix.htm>

Effective Date: The information contained in this memorandum clarifies current policy and must be implemented no later than 30 days after issuance of this memorandum. The information will be incorporated into the State Operations Manual, Appendix PP.

Training: This clarification should be shared with all survey and certification staff, surveyors, their managers, and the state/RO training coordinator. Please direct any question or comments to Jeane Nitsch at Jeane.Nitsch@cms.hhs.gov.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management
Quality Improvement Organizations

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification
Group

Ref: S&C-07-25



DATE: July 6, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes** - Issuance of Revised Guidance for 42 C.F.R. § 483.25(h)(1) and (2): Accidents and Supervision Guidance (Tags F323 and F324 combined into one tag F323) as Part of Appendix PP, State Operations Manual, and Training Materials

Memorandum Summary

- F323 and F324 are combined to create F323.
 - Revised guidance for long-term care surveyors regarding 42 C.F.R. §483.25(h)(1)and(2): Accidents and Supervision (Tag F323) will be effective August 6, 2007.
 - An advance copy of this guidance and training materials are attached.
- This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in the revised guidance by the implementation date.

Revised surveyor guidance for surveying Accidents and Supervision (Tag F323) requirements in long-term care facilities will become effective on August 6, 2007. At that time, a final copy of this new guidance will be available at <http://www.cms.hhs.gov/Transmittals/> and ultimately incorporated into Appendix PP of the State Operations Manual. Also, we will discontinue the use of Tag F324 when surveying for compliance in the area of Accidents and Supervision.

Here, we are providing an advance copy of the revised Accidents and Supervision guidance, which addresses the interpretive guidelines, the investigative protocol, and determination of compliance. The interpretive guidelines clarify areas such as resident supervision, hazard identification and resident risk, falls, unsafe wandering/ elopement, environmental assessment of hazards, and resident-to-resident altercations. The investigative protocol explains objectives and procedures surveyors will need for their investigation. Deficiency categorization provides severity guidance for the determination of the correct level of severity of outcome to residents from deficiencies found at Tag F323.

Also attached to this memo are training materials for the revised Tag F323. This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in the revised guidance by the implementation date. We encourage training be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. Additionally, you may use these training materials with provider groups and other stakeholders to communicate the guidance changes.

Regional Office (RO) training coordinators must document the completion of training on this new guidance for all RO and State nursing home surveyors within their region.

Enclosed with this memorandum are the following files:

- Guidance Training Instructor Guide – (pdf file);
 - PowerPoint presentation file – (PowerPoint file); and
- Advance copy of surveyor guidance on Tag F323 Guidance – (pdf file).

For questions on this memorandum, please contact Jeane Nitsch at 410-786-1411 or James Merrill at 410-786-6998 or via email at Jeane.Nitsch@cms.hhs.gov or James.Merrill@cms.hhs.gov

Effective Date: August 6, 2007. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: The materials should be distributed immediately to all State Agencies and training coordinators.

/s/
Thomas E. Hamilton

Attachments can be viewed at the following link under downloads:

<http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1201011&intNumPerPage=10>

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-28
(revised 7-25-07)

DATE: July 13, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Enforcement of the Requirement to Provide Medicare Beneficiaries Notice of Their Rights, Including Discharge Appeal Rights.

*** This memorandum includes updated standardized notices, "Important Message from Medicare" (in English and Spanish) originally included in the memorandum released July 13, 2007. It does not represent any significant content changes, just new formatting. It should replace that memorandum. ***

Memorandum Summary

The final rule governing beneficiary notification of their discharge appeal rights, published on November 27, 2006, requires updated enforcement guidance, effective July 2, 2007.

For hospitals, enforcement of the new notice requirements falls under the Patients' Rights Condition of Participation (CoP) at 42 CFR 482.13.

For critical access hospitals (CAHs), enforcement of the new notice requirements falls under the Compliance with Federal, State, and local laws and regulations CoP at 42 CFR 485.608(a).

The final rule governing notification to Medicare beneficiaries of their hospital and CAH discharge appeal rights, was published on November 27, 2006 (See Federal Register, 71 FR 68708). Under the final rule, 42 CFR 405.1205(b) requires that hospitals and CAHs provide each Medicare beneficiary who is an inpatient a standardized notice, the Important Message from Medicare (IM), within two days of their admission. The template for the IM is enclosed with this letter. The rule also requires that the IM be signed and dated by the patient when it is delivered to the beneficiary at or near admission. In addition, the rule at 42 CFR 405.1205(b)(3) requires that hospitals and CAHs present a copy of the IM to beneficiaries as far as possible in advance of their discharge, but not more than two calendar days before discharge. In the case of a short inpatient stay, however, where delivery of the IM is within two calendar days of the date of discharge, the second delivery of the IM is not required.

In addition, 42 CFR 489.27(b) requires hospitals and CAHs to demonstrate compliance with this requirement, cross-referencing the requirements at 42 CFR 405.1205.

Enforcement of the discharge notice requirement is linked to the Patients' Rights CoP for hospitals and the Compliance with Federal, State, and local laws and regulations CoP for CAHs.

The Patient's Rights CoP for hospitals at 42 CFR 482.13(a)(1) requires hospitals to inform each Medicare beneficiary of their rights as a patient prior to providing or discontinuing hospital care. The CoP at 42 CFR 485.608 requires that the CAH and its staff be in compliance with applicable Federal, State, and local laws and regulations.

Beginning July 2, 2007, the compliance of hospitals and CAHs with the new, more specific, discharge notice requirements of 42 CFR 489.27 and 42 CFR 405.1205 is to be assessed when surveying hospitals for compliance with the Patients Rights CoP and CAHs for the Compliance with Federal, State, and local laws and regulations CoP. The interpretive guidelines in the State Operations Manual (SOM) for the Patients' Rights CoP for hospitals and the Compliance with Federal, State, and local laws and regulations CoP for CAHs are being amended to reflect the regulatory requirements governing notification of Medicare beneficiaries, who are inpatients, of their discharge appeal rights.

Surveyors must verify that the hospital/CAH has appropriate policies and procedures in place to ensure that Medicare beneficiaries receive timely notice of their inpatient rights at admission, and if applicable, upon discharge. In addition, surveyors must review selected Medicare patient records to confirm that the records contain documentation verifying timely delivery of the IM, including, where applicable, delivery of a follow-up copy of the IM. Surveyors may also interview hospital/CAH staff to assess their knowledge and understanding of the IM delivery requirements, including the hospital's/CAH's process for delivering the IM and obtaining signature from the patient. Surveyors may also interview patients to verify that the hospital/CAH is providing Medicare beneficiaries with the IM in compliance with the regulatory requirements.

For questions regarding enforcement of the requirements for hospitals under the Patients' Rights CoP, please contact David Eddinger at 410-786-3429 or David.Eddinger@cms.hhs.gov.

For questions regarding enforcement of the requirements for CAHS under the Compliance with Federal, State, and local laws and regulations CoP, please contact Cindy Melanson at 410-786-0310 or Cindy.Melanson@cms.hhs.gov. Should you have any other questions regarding the content of this letter, please contact Aviva Walker-Sicard at 410-786-8648 or Aviva.walker-sicard@cms.hhs.gov.

Effective Date: July 2, 2007. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

Training: The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

/s/

Thomas E. Hamilton

Attachments can be viewed at the following link under downloads:

<http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1201180&intNumPerPage=10>



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-29

DATE: July 13, 2007

TO: State Survey Agency Directors
State Fire Authorities

FROM: Director
Survey and Certification Group

SUBJECT: **Life Safety Code** – Canopy and Overhang Sprinkler Requirements and the Use of the Fire Safety Evaluation System (FSES)

Memorandum Summary

- This memorandum modifies S&C-05-38 “Clarification of Life Safety Code (LSC) issues in Nursing Homes” in regards to sprinklers in canopies and overhangs.
- The LSC requires that most canopies and large overhangs be sprinklered (in facilities where the regulations require sprinklers).
- The Fire Safety Evaluation System (FSES) may be used when evaluating the level of safety provided for a Health Care occupancy where a canopy or overhang is required to be sprinklered. The FSES affords facilities the opportunity to have stronger safety features in other areas to compensate where the facility does not have sprinklers installed. The FSES can be used for this purpose until the Centers for Medicare & Medicaid Services (CMS) regulations require that the facility become fully sprinklered.
- Facilities with an existing waiver of the requirement for canopies and overhangs to be sprinklered may continue under their existing waiver if the CMS regional office (RO) finds that the waiver continues to meet all other requirements in law or regulation. These waivers are reviewed annually by the CMS RO. CMS will not approve any new waivers.

This memorandum clarifies CMS policy regarding the use of the FSES when determining compliance with the LSC where canopies or overhangs are not sprinklered. The LSC requires sprinkler systems to be installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, 1999 edition.

The Standard for the Installation of Sprinkler Systems, NFPA 13 (Section 5-1.1) requires:

“... (1) Sprinklers installed throughout the premises...” An annex note discusses that this standard contemplates full sprinkler protection for all areas.

At Section 5-13.8.1, NFPA 13 requires that sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width with an exception for those with noncombustible or limited combustible construction.

Use of the FSES

The FSES/HC (NFPA 101A, Chapter 4, 2001 edition) can be used to evaluate the level of safety provided for a Health Care occupancy that does not conform to the provisions of “Automatic Sprinklers and Other Extinguishing Equipment” (NFPA 101, Section 9.7). Facilities without sprinklers installed under overhangs or canopies may meet the requirements of NFPA 13 at Section 5-1.1 and 5-13.8.1 temporarily by using the FSES.

The 2001 edition of the FSES/HC (which is currently used by CMS) contains additional information on automatic sprinkler requirements that was not included in the 1985 edition of the FSES. This additional information may be helpful to facilities using the FSES in complying with automatic sprinkler requirements. Facilities using the FSES when canopies and overhangs do not have sprinklers installed would only receive credit for “Corridors and Habitable Space” or 8 points when evaluating item 13: Automatic Sprinklers. Facilities may only use the FSES to comply with these requirements until CMS regulations require that the facility become fully sprinklered. The FSES is required to be completed annually after each prescriptive survey and submitted as part of the facility’s plan of correction. The CMS Regional Office will review the completed FSES annually.

Use of a Waiver

Generally, facilities with an existing waiver of the requirement for canopies and overhangs to be sprinklered may continue under that waiver so long as the CMS RO finds that all other applicable requirements in law and regulation continue to be met. However, requests for new waivers are not to be approved, as the FSES provides a structured evaluation showing equivalency to the LSC due to compensatory features. Existing waivers may be continued until CMS regulations require that the facility become fully sprinklered. These waivers are to be reviewed annually by the CMS Regional Office.

The date at which time facilities will be required to be fully sprinklered by installing a sprinkler system in accordance with NFPA 13 will be determined in the final version of the proposed regulation issued October 27, 2006 as a Notice of Proposed Rulemaking (NPRM).

We hope this information is useful in clarifying this issue. If you have further questions, regarding this matter, please contact James Merrill at James.Merrill@cms.hhs.gov.

Effective Date: The information contained in this memorandum is current policy and is in effect for all nursing home facilities. The State agency should disseminate this information within 30 days of the date of this memorandum.

Training: This clarification should be shared with all survey and certification staff, fire authorities, surveyors, their managers, and the State/RO training coordinator.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-30

(revised)

DATE: August 10, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes** - Issuance of New Tag F373 (Paid Feeding Assistants) as Part of Appendix PP, State Operations Manual, Including Training Materials

*****The effective date of this guidance has been changed to coincide with the earlier than anticipated release of the official transmittal on August 17, 2007*****

Memorandum Summary

- New guidance for long-term care surveyors regarding the requirements for Paid Feeding Assistants will be published August 17, 2007.
- An advance copy of this guidance and training materials are attached.
- This training packet is to be used to train all surveyors who survey nursing homes by the implementation date.

The Centers for Medicare & Medicaid Services (CMS) published a final rule on September 26, 2003 (68 FR 55528) that allowed long-term care facilities to use paid feeding assistants under certain conditions. States must approve training programs for feeding assistants using federal requirements as minimum standards. Feeding assistants must successfully complete a State-approved training program and work under the supervision of a registered nurse or licensed practical nurse. The intent of this rule is to provide more residents with help in eating and drinking and reduce the incidence of unplanned weight loss and dehydration.

New surveyor guidance including interpretive guidelines and severity guidance has been developed for the implementation of this regulation through the new Tag F373 – Paid Feeding Assistants. This new guidance for surveying long-term care facilities will become effective August 17, 2007. At that time, a final copy of this new guidance will be available at <http://www.cms.hhs.gov/Transmittals/> and ultimately incorporated into Appendix PP of the State Operations Manual.

We are providing you with an advance copy of the new Paid Feeding Assistant guidance which contains the interpretive guidelines, investigative protocol, and deficiency categorization. The interpretive guidelines provide terminology and information regarding the use of paid feeding assistants that surveyors will need to apply the regulation. The investigative protocol explains the investigation's objectives and procedures surveyors will need for their investigation and determination of compliance. The deficiency categorization provides criteria for the determination of the correct level of the severity of outcome to any resident(s) from any deficient practice(s) found at Tag F373.

Also attached to this memo are training materials for the new Tag F373. These training materials are to be used to train all surveyors who survey nursing homes by the implementation date. We encourage training to be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. The training materials may also be used to communicate with provider groups and other stakeholders.

Regional Office (RO) and State Survey Agency (SA) training coordinators must document the completion of training on this new guidance for all RO and State nursing home surveyors within their region utilizing the Learning Management System (LMS) – a course code will be provided through one of the Survey and Certification Regional Training Administrator (RTA) teleconferences.

Enclosed with this memorandum are the following files:

- Advance copy of Paid Feeding Assistants guidance (F373) – (PDF);
- Training Instructor Guide – (PDF); and
- PowerPoint presentation file – (PowerPoint file).

For questions on this memorandum, please contact Susan Joslin at 410-786-3516 or via email at Susan.Joslin@cms.hhs.gov.

Effective Date: This guidance is expected to be published in final on August 17, 2007.

Training: The materials should be distributed immediately to all State Agencies and training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Enclosures: Advance copy of Paid Feeding Assistants guidance (F373)
PowerPoint Presentation
Training Instructor Guide

Attachments can be viewed at the following link under downloads:

<http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1202008&intNumPerPage=10>

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-36

DATE: September 14, 2007
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Release of Report "Study of Paid Feeding Assistant Programs"

Memorandum Summary

Announces the release of the "Study of Paid Feeding Assistant Programs" report and Web site location.

Background

On September 26, 2003, the Centers for Medicare & Medicaid Services (CMS) published a Federal Register (FR) notice enabling long-term care facilities to use paid feeding assistants to supplement the services of nursing assistants during mealtimes. Paid feeding assistants, as defined by the Federal rule, were to be used only with residents who did not have complicated feeding problems. The regulation, "Requirements for Paid Feeding Assistants in Long-term Care Facilities" (68 FR 55528), had two immediate goals:

- To increase the availability of staff during mealtimes; and
- To mandate minimum training and supervision standards for paid feeding assistant programs.

Various stakeholder groups raised concerns about the new law's implications for resident care and safety, and for staffing configurations. In June 2004, as a result of concerns raised, the CMS and the Agency for Health Care Quality and Research (AHRQ) sponsored a nationwide two-phase study to gain an understanding of the characteristics of paid feeding assistant programs. We are pleased to announce that the Phase I report, "Study of Paid Feeding Assistant Programs," is now available at http://www.cms.hhs.gov/CertificationandCompliance/12_NHs.asp#TopOfPage. This report provides:

- A description of the degree of implementation of paid feeding assistant programs nationally;
- The characteristics of and design of these programs; and
- The effect paid feeding assistants have had on the quality of care in nursing homes.

Phase I Report Findings

The study found that paid feeding assistant programs are generally regarded as an improvement in resident dining with no significant concerns noted and there was little to no variation in quality of assistance provided by paid feeding assistants versus that provided by nursing assistants. Further, the report reveals staffing configurations have not changed since most facilities recruit existing non-nursing facility staff to function as a paid feeding assistant.

Action Steps

The CMS initiated strategic actions based on the findings and recommendations in this report. We created and delivered satellite training for nursing home providers to assist them with the implementation of paid feeding assistant programs in their facilities. The satellite broadcast, "How to Enhance the Quality of Dining Assistance in Nursing Homes," aired in March 2007 and remains accessible on the CMS internet streaming Web site (<http://cms.internetstreaming.com>).

CMS issued surveyor interpretive guidelines and an investigative protocol as well as Power Point training to explain the regulatory mandates. This is available on the Survey & Certification Policy & Memos Webpage as S&C-07-30 released August 10, 2007.

For questions about this memorandum, please contact Susan Joslin at 410-786-3516 or via email at susan.joslin@cms.hhs.gov.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachment

Attachments can be viewed at the following link under downloads:

<http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1203286&intNumPerPage=10>



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-38

DATE: September 28, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Pre-Admission Screening and Resident Review (PASRR) and the Nursing Home Survey Process

Memorandum Summary

- ☐ In response to the Office of Inspector General's (OIG) recommendation in reports OEI-07-05-00230, "Pre-admission Screening and Resident Review for Younger Nursing Facility Residents with Mental Retardation" and OEI-05-05-00220 "Preadmission Screening and Resident Review for Younger Nursing Facility Residents with Serious Mental Illness," the Centers for Medicare & Medicaid Services (CMS) is clarifying the current nursing facility survey process related to the selection of sampled residents with serious mental illness and mental retardation, to ensure that surveyors review required PASRR documentation.
- ☐ PASRR requirements are found in the State Operations Manual (SOM), Appendix P Survey Protocol for Long-Term Care Facilities and Appendix PP Interpretive Guidance for Long-Term Care Facilities.
- ☐ Rebroadcast of PASRR satellite, "Mental Illness in Nursing Homes" will air on September 28, 2007, 1:00 – 3:30 PM EST and is accessible for viewing one year from the date of broadcast at <http://www.cms.internetstreaming.com>.

PASRR is a Medicaid program requirement that identifies individuals with serious mental illness and mental retardation (MI/MR) who apply to or reside in a nursing facility (NF), and specifies services required in order for the placement to be appropriate.

The OIG reports recommend that State surveyors:

- ☐ sample residents with serious mental illness and mental retardation,
- ☐ review all PASRR documentation for timely completion, and
- ☐ review care plans for incorporation of all Level II PASRR MI/MR service recommendations.

Current CMS survey process pertinent to PASRR can be found in Appendices P and PP of the State Operations Manual (SOM). Appendix P, Survey Protocol for Long-Term Care Facilities, makes reference to determining whether residents with a diagnosis of MI/MR are included in the selected sample. The following are examples of tasks that refer to PASRR or MI/MR:

- ☐ Task 1-Offsite Survey Preparation, section B - Information Sources for Offsite Survey Preparation, item 7, informs the surveyor that some States have formal mechanisms to share PASRR reports with the survey agency. If this information is available, evaluate if there are potential concerns and note names of residents for possible inclusion in the sample.
- ☐ Task 4-Sample Selection, section D. Protocol, item 3 - Special Factors to Consider in Sample Selection, lists “Residents with mental illness and mental retardation” as one of several factors to consider in determining which residents to select.

The specific regulatory requirements and guidance to determine a facility’s compliance with PASRR are found in Appendix PP, Interpretive Guidance for Long-Term Care Facilities at:

- ☐ F285 - 42 CFR 483.20(e) – “Coordination. A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicate testing and effort.”
- ☐ The Interpretive Guidance for F285 clarifies State responsibilities: “With respect to the responsibilities under the PASRR program, the State is responsible for conducting the screens, preparing the PASRR report, and providing or arranging the specialized services that are needed as a result of conducting the screens. The State is required to provide a copy of the PASRR report to the facility.” The PASRR report consists of determinations and an evaluation report as required in part 483 subpart C and is collectively known as PASRR Level II.
- ☐ The regulation at 42 CFR 483.20(m)(1) indicates that a NF must not admit any individuals with MI or MR, (as defined in regulation), unless the State mental health/mental retardation or developmental disabilities authority has determined that placement in a NF is appropriate, and if specialized MI/MR services are needed. This means that NFs are not in compliance if individuals with possible MI/MR were admitted without complete PASRR Level II documentation indicating that the admission was appropriate.
- ☐ The Probes for 483.20(m) reference whether complete PASRR Level II documentation was in place prior to admission of individuals with MI or MR.
- ☐ F406 - 42 CFR 483.45(a) – “Specialized Rehabilitative Services. Provision of Services.” The guidance under “Intent” distinguishes specialized rehabilitative services for MI/MR (which it terms “Mental health rehabilitative services for MI and MR”), from PASRR “Specialized services for MI/MR” provided or arranged for by the State. Both types of services are to be specified in the PASRR Level II documentation. The NF provides or obtains specialized rehabilitative services “within the scope of facility services,” but “they must be provided by or coordinated by qualified personnel.” The NF should provide specialized rehabilitative services which “complement, reinforce, and are consistent with any specialized services (as defined by the resident’s PASRR) . . . [the] plan of care should specify how the facility will integrate relevant activities throughout all hours of the individual’s day at the NF to achieve this consistency and enhancement of PASRR goals. The surveyor should see competent interaction by staff at all times, in both formal and informal settings in accordance with the individual’s needs.”

- The Guidance to Surveyors section “Procedures” found at F406 states, “For sampled residents, whose comprehensive assessment indicates physical, psychosocial, and/or communications rehabilitation potential, (See MDS 2.0, Sections G, C, F, E) observe for unmet needs for rehabilitative services. Determine the extent of follow-through with comprehensive care plan ...”

Summary: Surveyors are to review the records of selected sample residents with MI/MR to ensure that the nursing facility complies with PASRR requirements related to pre-admission screens, resident reviews, determinations for specialized services, and that all care and services are provided in accordance with the plans of care.

For questions concerning this memorandum, please contact Rosemary Dunn by e-mail at Rosemary.Dunn@cms.hhs.gov or call 410-786-1372.

Effective Date: This guidance is currently in effect and should be shared with all survey and certification staff, their managers, the state training coordinators and all long-term care providers within 30 days.

- **Training:** A re-run of the satellite “Mental Illness in Nursing Homes,” an excellent resource regarding PASRR survey protocol and regulations, is scheduled for September 28, 2007 at 1:00 -3:30 pm EST and is accessible for viewing one year from the date of broadcast at <http://www.cms.internetstreaming.com>. This satellite is mandatory for all surveyors.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-39

DATE: September 28, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Homes – Medication Pass Clarification for Surveying F Tags 332 and 333 During Nursing Home Surveys

Memorandum Summary

- ☐ A nursing home's noncompliance with the administration of nutritional and dietary supplements should not be included in the calculation of the facility's medication error rate at F332 or as a significant medication error at F333.
- ☐ We expect that the nursing home staff, along with the prescriber and consulting pharmacist, are aware of, review for, and document any potential adverse consequences between medications, nutritional supplements, and dietary supplements that a resident is receiving.
- ☐ Medication errors involving vitamins and/or minerals should be documented at F332 and counted towards the 5 percent error rate but would not be considered to be a significant medication error unless the criteria at F333 were met.

Background

Because some facilities may record the administration of nutritional and dietary supplements on the medication administration record (MAR) and as a result, these products may have been interpreted as medications, we are providing the following clarifications as to:

- ☐ Whether nutritional and dietary supplements should be evaluated as medications during the medication pass review performed during survey; and
- ☐ Whether to include nutritional and/or dietary supplements that are not administered according to physician's orders, in the calculation of the facility's medication error rate.

Discussion

Nutritional or dietary supplements are not explicitly defined in the State Operations Manual (SOM), Appendix PP. We are providing the following guidance regarding these types of supplements:

- “Nutritional Supplements are medical foods that are used to complement a resident’s dietary needs. Examples of these are total parenteral products, enteral products, and meal replacement products (e.g., Ensure, Glucerna and Promote.)”¹
- “Dietary Supplements - Herbal and alternative products are considered to be dietary supplements. They are not regulated by the Food and Drug Administration (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). If a dietary supplement, given to a resident between meals, has a vitamin(s) as one or more of its ingredients, it should be documented and evaluated as a dietary supplement, rather than a medication. Keep in mind that, for clinical purposes, it is important to document a resident’s intake of such substances elsewhere in the clinical record and to monitor their potential effects, as they can interact with other medications.”²

Because nutritional and dietary supplements are not considered to be medications for purposes of federal nursing home surveys, noncompliance with the administration of these products should not be included in the calculation of the facility’s medication error rate at F332 or as a significant medication error at F333.

It is expected that the facility staff, along with the prescriber and consulting pharmacist, are aware of, review for, and document any potential adverse consequences between medications, nutritional supplements, and dietary supplements that a resident is receiving.

Medication errors involving vitamins and/or minerals should be documented at F332 and counted towards the 5 percent error rate. Medication errors involving vitamins and minerals would not be considered to be a significant medication error unless the criteria at F333 were met. An example of a significant medication error related to vitamin administration could be: failure to administer Vitamin K for a resident with complications related to warfarin which was prescribed by a physician. The CMS Long-Term Care Facility Resident Assessment Instrument User’s Manual provides guidance to code medications administered in the past seven days which includes the administration of vitamins.³

For questions on this memorandum, please contact Linda O’Hara at 410-786-8347 or via email at linda.ohara@cms.hhs.gov).

¹ Pharmacy Times, 71(1): p. 28, 31-32. 2005.

² CMS Long-Term Care Facility Resident Assessment Instrument User’s Manual Version 2.0. “Section O. Medications,” 2002, p 3-177.

³ Ibid., p. 3-177,

Page 3 – State Survey Agency Directors

Effective Date: Immediately. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: The materials should be distributed immediately to all State Agencies and training coordinators.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-08-01

DATE: October 24, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Survey & Certification Emergency Preparedness Initiative: Provider Survey & Certification Declared Public Health Emergency FAQs – All Hazards

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) Survey & Certification Group has developed a Frequently Asked Question (FAQ) document which uses an all hazards approach to address allowable deviations from provider survey and certification requirements during a declared public health emergency.
- CMS developed these FAQs with the input and feedback of the Survey and Certification Emergency Preparedness Stakeholder Communication Forum, based on the experience and lessons learned during Hurricane Katrina.

Background

The Centers for Medicare & Medicaid Services (CMS), Survey and Certification Group has been working in collaboration with Federal and State healthcare stakeholders to provide an effective emergency response that will protect the health and safety of patients and residents in the face of any potential disruptive event.

This memo, one of the survey and certification (S&C) communication and outreach strategies, provides a FAQ document to provide direction on allowable deviations from provider survey and certification requirements during a declared public health emergency. Similar to other aspects of the S&C Emergency preparedness Initiative, the FAQs have been developed utilizing an “all hazards” approach (e.g., hurricane, tornado, earthquake, flood, fire, chemical spill, nuclear or biological attack, pandemic flu, etc.).

The FAQs are general in nature, and were based upon the experience and lessons learned from Hurricane Katrina. Input for these FAQs has been obtained from the CMS S&C Emergency Preparedness Stakeholder Communication Forum and other Department of Health and Human Services (HHS) operating divisions.

Please see the attached *CMS Provider Survey and Certification Frequently Asked Questions – Declared Public Health Emergencies – All Hazards* document. CMS will post these questions and answers on the CMS FAQ Website, which may be accessed at:

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=_YCKDVOi

Click on the “Section” field, and then select “Disasters and Emergencies.” Several CMS sub-categories may be selected. These FAQs will be accessible in the sub-category entitled “Provider Survey/Certification.” (See attached CMS Frequently Asked Question screen).

CMS will review and update the Provider Survey and Certification Public Health Emergency FAQs as new emergency situations and issues develop.

S&C Emergency Preparedness Web site

CMS has also established the Survey and Certification Emergency Preparedness Web site to provide State Survey Agencies (SAs), health care providers, and other partners with “one-stop-shopping” for emergency preparedness information. The Web site provides links to many resources and other relevant Federal emergency preparedness Web sites. Links to State emergency preparedness Web sites will also be included as a helpful resource on the Web page developed for SAs. A variety of national experts and health care stakeholders have assisted CMS to develop several helpful emergency preparedness tools, such as checklists and reports, to help SAs and healthcare providers achieve an improved level of preparedness. Updates and new documents will be posted to the Web site on a regular basis. The S&C Emergency Preparedness Website can be accessed at: <http://www.cms.hhs.gov/SurveyCertEmergPrep/>.

If you have any questions about the S&C Emergency Preparedness Initiative, please contact Susan Larsen at 410-786-2640 or susan.larsen@cms.hhs.gov.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachments

Attachments can be viewed at the following link under downloads:

<http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1204638&intNumPerPage=10>

Center for Medicaid and State Operations/Survey & Certification Group

Ref: S&C-08-02

(Revised 12/7/07)

DATE: November 2, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Improvements to the National Special Focus Facility (SFF) Program for Nursing Facilities—Notice Requirements

This memorandum corrects footnotes “c” and “e” in the original memo concerning significant progress

Memorandum Summary

This memo amends S&C Memorandum 05-13 to improve the national “Special Focus Facility (SFF)” initiative. The SFF is designed to increase the probability that nursing homes which have consistently exhibited serious quality problems will significantly improve their quality of care and safety of residents in the near future. The revisions emphasize:

- **Improved notification** - so that administrators, owners, and boards of directors are all fully apprised of the seriousness of the issue and the imperative for action;
- **Public notice** – to provide a list of nursing homes that have been designated as a SFF and, after one survey, continue to provide poor care. This information will be made available on the Centers for Medicare & Medicaid Services Web site with a link from Nursing Home Compare; and
- **Focus on Quality of Care & Quality of Life Deficiencies** – Life Safety Code deficiencies will not be used in calculations.

A. Background

The SFF program, as strengthened in 2005^a:

1. Identifies the nursing homes whose quality of care has consistently demonstrated failure to maintain compliance and a history of facility practices that have resulted in harm to residents (as measured by the most recent three State recertification surveys). Federal law and regulations require nursing homes to meet nursing home requirements at the time of survey and to maintain compliance continuously;
2. Ensures that SFFs are surveyed with twice the frequency of health surveys than other nursing facilities; and

^a See S&C Memo 05-13 of December 16, 2004. The memo may be accessed on the CMS website at: <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp>

3. Ensures that effective action is taken, during and after a structured period of 3 standard surveys (approximately 18 months), so that facilities:
 - a. Graduate^b from the list if they have significantly improved (so as to make room for other nursing facilities that are not performing as well), or
 - b. Are provided additional time as an SFF nursing home due to promising developments and a recent trendline of improvement, or
 - c. Terminate from Medicare and/or Medicaid if they have not significantly improved.

Refinements described in our SFF procedures will increase the probability that significant improvements in quality of care will be made in the identified nursing homes. State Survey Agencies (SAs) will apply the procedures to both newly-identified SFF nursing homes and those nursing homes that are currently in the SFF program but have failed to improve significantly. Significant improvement means that a SFF is able to demonstrate that its practices have caused no actual harm, i.e., no deficiencies greater than “E” in terms of scope and severity.

The SFF program was initiated because a number of facilities consistently provided poor quality of care, but periodically instituted enough improvement in the presenting problems that they would pass one survey only to fail the next (for many of the same problems as before). Such facilities with a “yo-yo” history rarely addressed underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.

B. Improvements

Improved Notification

Initial Notice -- The changes described in the SFF procedures begin with the initial notification process. The previous Centers for Medicare & Medicaid Services (CMS) procedures did not ensure that all accountable parties were notified of the facility’s history of inadequate care, the reasons for the facility’s selection in the SFF program, what to expect as a result of such SFF selection, and the serious consequences that will occur in the event of a failure to improve. We believe it is particularly important that governing bodies, owners and operators, in addition to the nursing home administrators, be fully apprised of these facts at the beginning of their SFF period.

Removal from SFF Designation – Once a SFF has successfully met the criteria for removal, the SA will notify the SFF and all accountable parties that the facility is no longer designated as a SFF.

Public Notice

CMS will make public a list of nursing homes that have been designated as a SFF and, after one survey, fail to significantly improve care^c. SFFs that on a subsequent survey make significant progress will have their name removed from the list when the list is updated. This information will be made available on the CMS website with a link from Nursing Home Compare.

^b A SFF can graduate from the designation of a SFF when it demonstrates two consecutive standard surveys that it has deficiencies cited at a scope and severity level of no greater than “E” and no intervening complaint-related deficiencies cited greater than “E.”

^c Significant improvement means that a SFF is able to demonstrate that its practices have no deficiencies greater than “E.”

Focus on Quality of Care and Quality of Life Deficiencies -- So that States can focus more on quality of care and quality of life concerns in SFFs, we have removed Life Safety Code (LSC) deficiencies from the formula used to calculate the SFF candidate list. However, LSC surveys must still be completed with the same frequency as health care surveys, and any LSC finding of actual harm on the most recent survey will preclude graduation from the SFF initiative.

Effective Date: The changes included in the SFF procedures augment current guidance on SFF surveys. The policy for current SFF can be implemented as soon as the SA is ready but no later than 60 days from the date of this memo. The policy for newly selected SFF can be implemented as soon as the SA is ready, but no later than January 1, 2008.

Training: This policy must be shared with all survey and certification staff, surveyors and their managers, and the State and CMS RO training coordinators. This information must be shared with nursing home providers in each State.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachments:

SFF Procedures

Model letter for notification of SFF status

SPECIAL FOCUS FACILITIES - AMENDMENTS TO S&C MEMORANDUM 05-13

Background -- The SFF program was initiated because a number of facilities consistently provided poor quality of care, yet periodically instituted enough improvement in the presenting problems that they would pass one survey only to fail the next (for many of the same problems as before). Such facilities with a “yo-yo” history rarely addressed underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.

Once selected as a SFF, the State will conduct twice the number of standard surveys and will apply progressive enforcement until the nursing home either (a) graduates from the SFF program or (b) is terminated from the Medicare and/or Medicaid program(s).

Life Safety Code (LSC) -- Because the intent of this initiative is to focus on quality of life and quality of care issues, LSC deficiencies are not used in determining the list of facilities that are candidates for the SFF program. However, LSC surveys will be conducted at the same frequency as the health surveys (i.e., twice the number of standard surveys per year), and any LSC finding of actual harm on the most recent survey will preclude graduation from the SFF initiative during that survey cycle.

SECTION I. SFF CANDIDATE LIST

Quarterly Computation of SFF Candidate List

CMS computes a SFF candidate list each quarter. This computation is based on 3 years of survey history, the severity of deficiencies, and the number of deficiencies. Complaint deficiencies are also included in the computation. Each State selects its SFF from a list of approximately 15 eligible nursing homes in their own State with the worst compliance history based on these computations.

SECTION II. INITIAL SELECTION OF SFF AND EDUCATION

A. Notification

1. **Initial Notice --** The State notifies the facility and all accountable parties (see section B) by letter (and any additional means chosen by the SA) that:
 - The facility has been selected as a SFF facility;
 - The selection is due to its persistent pattern^d of poor quality on its last three standard surveys and complaints (i.e., 3 years of compliance history);
 - Serious consequences, including termination of the provider agreement, will result if significant improvements^e are not evident within the next three standard surveys (or 18 months, whichever is shorter). Include a description of the SFF program.
 - Irrespective of the SFF designation, advise the accountable parties that:

^d Persistent pattern of poor quality refers to 3 years of compliance history with deficiencies at a scope and severity of “Harm” or higher or history of Substandard Quality of Care.

^e Significant improvement means that a SFF is able to demonstrate that its practices have no deficiencies greater than “E.”

- The Social Security Act requires termination of the Medicare provider agreement no later than 6 months unless substantial compliance is achieved (as defined by the statute); and that
- Termination may occur more quickly than the six-month statutory date if serious deficiencies that evidence harm continue.

A model letter is included in Attachment A. States may tailor the communication to accommodate any special features for facilities in the State.

2. **Removal from SFF Designation** – The State should notify the SFF and all accountable parties that the facility is no longer designated as a SFF once it has successfully met the criteria for removal (See E). A copy should be sent to the additional parties listed in section C below.

B. Accountable Parties

Address or copy the communications to all of the following parties, since they are all accountable and in a position to effect necessary improvements:

- Administrator;
- Chairperson of the Governing Body or full Governing Body (as identified on Survey and Certification documents); and
- Owners and operators: This must include the holder of the provider agreement. If reasonably feasible for the State SA, the notification should also include other clearly identifiable owners (such as the owner of the building and land if separate from the holder of the provider agreement, and corporate owner(s) for chain-operated nursing homes).

A copy of any communication should be sent to the CMS Regional Office (RO) as well.

C. Additional Parties

Provide a copy to the State Ombudsman Office and the State Medicaid Director. If the second standard survey reveals that the facility continues to practice care that have resulted in harm to residents, then the State should notify the CMS-RO.

D. Other Considerations

We encourage face-to-face communications between the SA and the nursing home's accountable parties to the extent that State SA resources permit, as well as communication by additional written means, so as to ensure that the seriousness of being designated as a SFF is adequately understood.

Please maintain up-to-date communication with your CMS RO after surveys of SFF nursing homes.

E. Removal from the SFF Initiative

Once a SFF has completed 2 standard surveys with no deficiencies above a scope and severity of "E", and has no complaints with a scope and severity above an "E" during that time period, the nursing home is eligible for removal from the SFF Initiative.

**MODEL LETTER TO PROVIDER SELECTED AS A
“SPECIAL FOCUS FACILITY”**

IMPORTANT NOTICE – PLEASE READ CAREFULLY

(Date)

Nursing Home Administrator Name
Facility Name
Address
City, State, ZIP Code

Dear (Nursing Home Administrator)

This is to advise that [name of facility] has been designated by CMS as a “Special Focus Facility” (SFF) due to its history of noncompliance with quality of care and safety requirements under Medicare over the past three years. Such poor quality of care has been evident through standard survey results as well as deficiencies identified during complaint surveys. The purpose of this letter is to notify you of the seriousness with which we view such poor quality and to explain what such history means for your facility as it participates in the SFF initiative.

CMS began the SFF initiative to address the problem facilities that consistently provide poor quality of care but periodically make enough improvement in the presenting problems to pass one survey, only to fail the next (for many of the same problems as before). Facilities with such a “yo-yo” history rarely address the underlying systemic problems that give rise to repeated cycles of serious deficiencies.

What Does This Mean?

The SFF initiative is intended to promote more rapid and substantial improvement in the quality of care in identified nursing homes, and end the pattern of repeated cycles of non-compliance with quality of care requirements. SFF nursing homes are provided with more frequent survey and certification oversight. CMS’ policy of progressive enforcement means that any nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions, and/or termination of the Medicare provider agreement.

In light of your facility’s recent history of poor quality, the State survey agency (SA) will conduct two standard surveys per year in your facility, instead of the one required by law. We will also pay close attention to the proper application of CMS’ progressive enforcement policy. The progressive enforcement policy applies to all nursing homes, but is particularly important in the case of SFF nursing homes because such nursing homes have demonstrated such a serious and persistent pattern of poor quality.

How Does A Facility Get Removed From the SFF Program?

A nursing home may graduate from the SFF program when it demonstrates at two consecutive standard surveys that it has deficiencies cited at a scope and severity level of no greater than “E” and no intervening complaint-related deficiencies cited greater than “E.” However, if a facility has been unable to achieve survey results at a level of ‘no actual harm’ after three standard surveys (approximately 18 months), CMS may also remove a facility from the SFF program through termination of the Medicare provider agreement.

Enforcement for Lack of Significant Progress

CMS will impose an immediate sanction(s) with respect to your facility if it is cited with any deficiency(ies) on the first and each subsequent survey after it was designated as a SFF. Enforcement remedies will be of increasing severity. These will include, at a minimum, a Civil Money Penalty and/or a Denial of Payment for New Admissions. If, after 3 standard surveys (approximately 18 months) subsequent to being selected as a SFF, the nursing home fails to have made significant progress (i.e., unable to achieve a survey with 'no actual harm' and 'no substandard quality of care'), CMS will issue a notice of termination from the Medicare and Medicaid program unless there are substantial, new developments that indicate a high probability of improvement in the systems of care at the nursing home. If the provider agreement is terminated, CMS will consider the facility's status and progress (or lack of progress) as a SFF in setting a reasonable assurance period before a facility may be reinstated to participate in Medicare.

Can This Be Appealed?

Your selection as a SFF is not subject to appeal. However, you still have the right to informal dispute resolution regarding the findings of a survey (see 42 Code of Federal Regulations §488.331) and the right to appeal the noncompliance that led to a remedy through an Administrative Law Judge of the Department of Health and Human Services. Specific requirements for requesting a formal hearing are contained in the notice of the imposition of the remedy.

We encourage you to take this communication seriously, as it is based on serious and persistent quality of care problems for which you have responsibility. Most importantly, we hope you will take this opportunity to redouble efforts to improve the quality of care provided to residents in your nursing home.

We are also sending a copy of this notice to other accountable parties to give them notice of the designation of SFF for your facility^f.

If you have any questions, please contact (name, title, address, phone number, fax number and e-mail address of appropriate survey agency official.)

Sincerely,

(Name and Title)

cc: Chairperson, Governing Body
Not-for-Profit or For-Profit Owner & Operator
State Ombudsman
Quality Improvement Organization
CMS Regional Office

^f These may include the Governing Body, owner and operator. Notice may also be provided to the State Ombudsman, the State Medicaid Director, and the State Quality Improvement Organization.



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-08-03

DATE: November 5, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Initial Surveys for New Medicare Providers

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS), together with States, seek to maintain effective quality assurance in the Medicare program at the same time that:
 - Many new providers are applying to participate in Medicare for the first time;
 - Resources are highly constrained since the President's proposed budget for Survey & Certification (S&C) has not been fully funded for the past three consecutive years;
- Appendix A therefore contains revised survey priorities and procedures to ensure that we obtain greater value from each survey dollar expended, and that CMS' priority structure for survey and certification activities are followed faithfully (see Appendix A);
- CMS longstanding policy makes complaint investigations, recertifications, and other core work for existing Medicare providers a higher priority compared with certification of new Medicare providers. We retain and affirm the advisability of those priorities;
- Providers that have the option of attaining accreditation that conveys deemed Medicare status conducted by a CMS-approved accreditation organization (in lieu of Medicare surveys by CMS or States) are advised that such deemed accreditation is likely to be the fastest route to certification;
- While accreditation by an accreditation organization does not suffice to demonstrate compliance with the special requirements for certain hospitals (such as rehabilitation or psychiatric hospitals or IPPS-excluded units) that receive payment outside of the Inpatient Prospective Payment System (IPPS), proper attestation of compliance with IPPS-exclusion requirements (combined with the accreditation) will permit the State and CMS to act expeditiously on the hospital's application.

Background

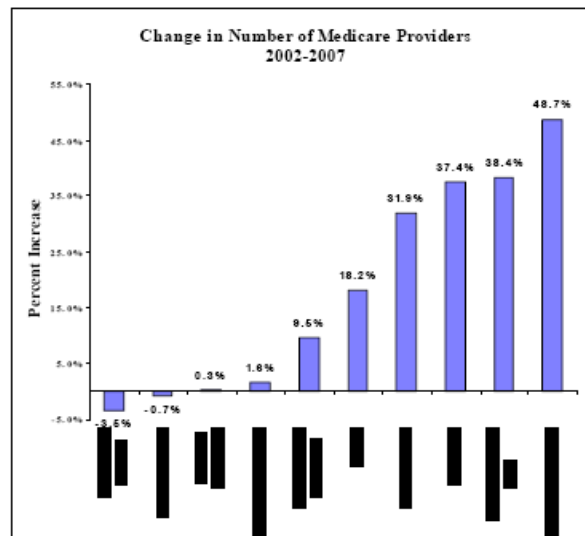
The Social Security Act (the Act) provides for a system of quality assurance in the Medicare program based on objective, onsite, outcome-based surveys by federal and State surveyors. The survey and certification (S&C) system provides beneficiaries with assurance that basic standards of quality are being met by health care providers or, if not met, that remedies are promptly implemented.

CMS accomplishes these vital quality assurance functions under specific direction from the Act and in concert with States, CMS-approved accreditation organizations (AOs), and various contracts with qualified organizations. All CMS or State certification surveys for Medicare must be performed by Medicare-qualified surveyors consistently applying federal regulations, protocols, and guidance. Most types of providers or suppliers seeking to participate in Medicare must first demonstrate compliance with quality of care and safety requirements through an on-site survey.

Initial surveys of new providers or suppliers have become more challenging for four reasons:

Resource Limitations: For the past three consecutive years the final federal budget for Medicare survey and certification has been considerably less than the level requested by the President. The FY 2007 appropriation, for example, was \$25 million less than the President's budget request (and lower than FY 2005 levels). Although we remain hopeful that the FY 2008 appropriation will fully fund the President's request, it may be well into the fiscal year before Congress enacts the final FY 2008 budget.

Many New Providers: Many additional providers have been seeking to participate in the Medicare program. Since 2002, for example, the number of Medicare-participating rural health clinics has increased by 48.7%, ambulatory surgical centers by 38.4%, hospices by 37.4%, home health agencies by 31.9%, dialysis facilities by 18.2%, and non-accredited hospitals by 9.5%. The graph to the right portrays the growth between 2002 and 2007 in the number of different providers and suppliers that constitute the main survey and certification workload.



More Responsibilities: Additional survey responsibilities, such as new responsibility for surveys of hospital transplant programs beginning in late 2007, have further stretched survey resources and have increased the need to pay careful attention to survey priorities.

Anti-fraud Initiatives: Growth in the number of certain provider types, particularly home health, has been accompanied by evidence of higher levels of fraudulent activity by a minority of such providers. The Secretary's recent anti-fraud initiatives have called upon survey and certification to conduct additional surveys in certain areas where change of ownership indicates the need for closer review.

CMS Priorities

Longstanding CMS policy makes complaint investigations, recertifications, and core infrastructure work for existing Medicare providers a higher priority compared with certification of new Medicare providers. CMS directs States to prioritize federal survey functions in four priority "Tiers." Tier 1 consists of statutory mandates, such as surveys of existing nursing homes and home health agencies. Tier 4 consists of other important work, but work that is considered

reasonable to accomplish only if higher priority functions can be accomplished within the federal budget limitations.

Many provider or supplier types (such as hospitals, ambulatory surgery centers, hospices, and home health agencies), have the option of becoming Medicare-certified on the basis of accreditation by a CMS-approved AO instead of a survey by CMS or States. In such cases, the applicants have an alternate route to Medicare certification via CMS' acceptance of the AO's accreditation. While the applicant will pay a fee to the AO for the initial survey, applicants may conclude that the benefits outweigh the expense, particularly the expense of time waiting for a no-cost CMS survey. Similarly, clinical laboratory surveys are not subject to the CMS prioritization structure because the laboratories pay a fee to CMS for the laboratory certification work. For all initial Medicare surveys conducted by CMS or States, there is no cost to the applicant, but the resource limitations described here require that we adhere to a clear sense of priorities in conducting our work.

Most initial surveys for providers or suppliers seeking to participate in Medicare for the first time are prioritized in a lower priority (Tier 4) for CMS and State survey agency (SA) work compared to complaint investigations and recertification of existing providers or suppliers. The increasing severity of S&C resource limitations means that the effect of this longstanding CMS priority on providers and suppliers is more pronounced now than it has been in the past. The situation is different for each State, since some States have seen a large number of new providers seeking Medicare participation while other States have not seen such an increase.

Different providers/suppliers may also experience unique options and circumstances, so that a common policy may have a different impact on different providers. We are therefore refining the CMS policy for initial surveys in order to recognize the different situations being experienced by different providers and suppliers. The revised policy in **Appendix A** accomplishes a number of objectives:

- ***Process for Exceptions:*** The revised policy explains the process by which providers or suppliers in certain unique circumstances may request from CMS an exception in their priority assignment.
- ***Higher Priority for Some Unique Situations:*** The "Tier 3" priority is expanded to raise the priority level for providers or suppliers in certain unusual circumstances without needing to request any special exception.
- ***Tier 4 Options:*** The revised policy offers a better explanation of the options available to providers whose application for new participation in Medicare represents a Tier 4 priority for survey and certification. These changes are particularly relevant to hospitals that offer services that are excluded from the Inpatient Prospective Payment System (IPPS). They provide methods by which proper attestation of compliance with IPPS-exclusion requirements (combined with the accreditation) will permit the State and CMS to act expeditiously on the hospital's application.

In the future, CMS will explore additional actions that may strengthen oversight of hospital rehabilitation and psychiatric services, including:

- (a) Revising the Medicare hospital Conditions of Participation to include the special requirements for rehabilitation and psychiatric services that are now addressed only in the IPPS-exclusion requirements at 42 CFR 412, and
- (b) Conducting onsite surveys for a sample of hospitals that provide rehabilitation or psychiatric services, based on an analysis of the degree to which there may be risk of noncompliance with the IPPS-exclusion requirements. Existing hospitals, as well as new hospitals, would be included in the sample.

Appendix B contains an example of content that may be useful in communicating these priorities to applicants.

Appendix C contains the addresses for all of the AOs whose accreditation we have deemed for Medicare certification purposes. Please convey this information to prospective providers or suppliers who have the option of deemed accreditation. Please note that some AOs offer accreditation for provider types for which deeming is not an option (either because deeming is not permitted under the law, or because no AO has submitted an approvable application to CMS). Examples include nursing homes and dialysis facilities. For each AO in Appendix C we have listed the provider or supplier types for which the AO's accreditation permits deemed status. If a provider or supplier type is not listed next to the name of a particular AO, then CMS does not deem such accreditation as meeting Medicare requirements.

Some provider types have the deemed accreditation option but an onsite CMS survey has been required to verify compliance with certain payment requirements related to exclusion from the inpatient prospective payment system (IPPS). The IPPS exclusion verification under 42 CFR 412 is a small but important aspect of the accreditation process for which the AO surveys are not deemed. To address this issue we are instituting a time-limited option process to treat the IPPS-exclusion verification for initial applications by signed attestation, the same manner in which such verification is handled for recertifications.

We hope this memorandum will assist States in both prioritizing survey work and in clearly communicating with providers and suppliers to understand:

- The reasons for CMS' priority structure for survey and certification work;
- The options that providers or suppliers have to obtain a survey that can establish their qualification to participate in Medicare;
- The length of time that may elapse before they may be surveyed, with as much certainty as possible given the annual federal budget and resource uncertainties. A clearer sense of the timeline will help providers and suppliers in better planning their efforts.

We request that States make the priority structure in Appendix A, and the procedures for providers that have an AO option, widely known to the provider/supplier community as soon as possible.

We hope the Appendix B potential content may be useful to assist States in offering prospective Medicare providers and suppliers with as much relevant information and timeline clarity as possible.

If you have any questions concerning this memorandum, please contact your CMS Regional Office.

Effective Date: The information contained in this memorandum is applicable immediately for all healthcare facilities that rely on CMS survey and certification work. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: This information should be shared with all appropriate survey and certification staff, surveyors, and the affected provider community.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Appendix A

CMS Priorities for Initial Surveys of Providers and Suppliers Newly Enrolling in Medicare

I. Priority Exception Requests

Access to Care Reasons: Providers or suppliers may apply to the State survey agency (SA) for CMS consideration to grant an exception to the priority assignment of the initial survey if lack of Medicare certification would cause significant access-to-care problems for beneficiaries served by the provider or supplier. The State SA may choose whether to make a recommendation to CMS before forwarding the request to the CMS Regional Office (RO).

There is no special form required to make a priority exception request. However, the burden is on the applicant to provide data and other evidence that effectively establishes the probability of serious, adverse beneficiary health care access consequences if the provider is not enrolled to participate in Medicare. CMS will not endorse any request that fails to provide such evidence and fails to establish the special circumstances surrounding the provider's request. We expect that such exceptions will be infrequent.

II. Accreditation Requests

SAs should continue to collect and forward to the CMS RO the certification packets¹ for facilities wishing to participate in Medicare through deemed accreditation, including attestation documents for those facilities seeking first-time IPPS exclusion.

III. Tier 3

- ESRD Facilities – Due to the unique reliance of dialysis patients on Medicare, and the fact that there are no deemed accreditation options for ESRD facilities, we accord such facilities a higher (Tier 3) priority than most other provider or supplier types.
- Transplant Centers –Transplant centers are accorded the higher Tier 3 priority because there are no CMS-approved accrediting organizations (AOs) for transplant centers. While this may change in the future, CMS has neither received nor approved any AO applications for transplant center accreditation to date. In addition, transplant patients (and donors) rely on Medicare in ways that other patients do not (such as special eligibility provisions for post-operative immuno-suppressive drug coverage when certain otherwise ineligible individuals receive transplants from a Medicare-certified center).
- Hospitals without an AO Option. In this context it is necessary to distinguish the health and safety standards of the certification process for participation in Medicare from verification of compliance with the requirements for exclusion from the Inpatient Prospective Payment System (IPPS).
 - Verification of compliance with IPPS exclusion criteria by whole hospitals or excluded units of short term acute care hospitals is addressed in the discussion of Tier 4 priorities, part V of this Appendix.

¹ Such as the completed provider agreement, applicable civil rights forms, completed worksheets where necessary, copy of the accreditation letter from the AO, etc.

- Surveys for the special psychiatric conditions of participation (CoPs) found at 42 CFR 482.60 through 482.62 will be done as a Tier 3 priority, typically by a CMS contractor. While psychiatric hospitals in general are eligible for deemed accreditation, no AO is approved for verification of compliance for the special psychiatric conditions of participation found at 42 CFR 482.60 through 482.62. We expect that the rest of the hospital's operations would achieve certification through deemed accreditation and that only the non-deemed part would be surveyed by the CMS as a Tier 3 priority.
- ***Critical Access Hospital (CAH) Distinct Part Units:*** A distinct part psychiatric or rehabilitation unit in a CAH must at this time rely on the higher Tier 3 priority, since the AO's currently approved for CAH certification have not been approved for deeming relative to such units. We anticipate that renewal applications by AOs to continue their authority for the CAH program will cover these distinct part units in the future. Only the distinct part unit(s) is eligible for Tier 3 priority, while the rest of the CAH has a deemed accreditation option. We will advise SAs when an AO has been approved to deem the distinct part units.

Note: Conversions of an existing provider under the same provider agreement- is not considered an initial application and the priority for initials does not apply. The provider/supplier types in this circumstance are:

- Conversion of a hospital to a CAH, or a CAH back to a hospital is a conversion (not an initial certification), and at State option may be done as Tier 2, 3, or 4. However, the addition of swing beds as a new service in an existing hospital or CAH is a Tier 4 priority, the same as a new nursing home service would be if it were started by a non-hospital.
- Similarly, the conversion of a Medicaid-only Nursing Facility (NF) to dual-certification (SNF/NF) does not require an initial certification survey and may be done at the State's discretion in accordance with SOM 7002.
- Nursing homes that convert to a Green House certified, resident-centered, culture change environment (which requires new construction).

IV. Tier 4

Accreditation Options: Initial certifications of all provider/supplier types that have the option to achieve deemed Medicare status by demonstrating compliance with Medicare health and safety standards through a survey conducted by a CMS-approved accreditation organization is a Tier 4 priority. In light of the federal Medicare resource constraints, we consider the cost of initial surveys to be the lowest priority for the Medicare program for those provider and supplier types that have a deemed accreditation option in those States unable to complete the higher-priority Tier 1-3 work.

Provider/supplier types with a Tier 4 priority for initial surveys because they have a deemed accreditation option include:

- Ambulatory Surgical Centers
- Home Health Agencies
- Hospices
- Hospitals
- Critical Access Hospitals

All Others: All other newly-applying providers/suppliers not listed in Tier 3 are Tier 4 priorities, unless approved on an exception basis by the CMS RO due to serious health care access considerations or similar special circumstances (see “Priority Exception Requests” above). The affected Medicare providers/suppliers include:

- Comprehensive Outpatient Rehabilitation Facilities
- Long Term Care Units in Hospitals
- Nursing Homes that do not participate in Medicaid
- Outpatient Physical Therapy
- Rural Health Clinics

V. Special Provisions for Compliance with IPPS-Exclusion Requirements

With respect to hospitals and CAHs, please note the following policy refinements:

1. *Rehabilitation Hospitals:* Rehabilitation hospitals are eligible for deemed accreditation, except for verification of the IPPS-exclusion requirements. Procedures for the IPPS-exclusion verifications are described below.

2. *Psychiatric Hospitals:* Psychiatric hospitals are eligible for deemed accreditation, except for the non-deemed special psychiatric CoPs at 42 CFR 482.60 through 482.62. While survey of the special conditions will be a Tier 3 priority for hospitals that have been otherwise deemed by an accreditation organization, survey for compliance with the rest of the hospital CoPs will remain a Tier 4 priority for CMS since the rest of the hospital survey may be accomplished by an AO.

3. *IPPS-Excluded Rehabilitation Hospitals, and IPPS-excluded Rehabilitation or Psychiatric Units of a Hospital:* Accreditation organizations do not have authority to verify a hospital’s or a hospital excluded unit’s compliance with the IPPS exclusion criteria at 42 CFR 412. Currently, annual re-verification of IPPS-exclusion for such excluded hospitals or units in already-certified hospitals is handled by provider self-attestation, but initial verification for first-time IPPS-exclusion has been required via certification surveys by the States.

Effective immediately we are suspending (until further notice) the requirement for an onsite IPPS-exclusion survey of all hospitals and units seeking first-time IPPS-exclusion (State Operations Manual (SOM) at section 3100 - 3108B), except for providers whose IPPS exclusion has previously been removed. Instead, such providers will be required to submit an attestation and completed Form CMS-437, CMS-437A or CMS-437B, whichever is applicable, indicating that all CMS exclusion requirements are met. Note that these attestation procedures apply to all hospitals and units that are IPPS-excluded.

In addition to the attestation and applicable Form CMS-437, rehabilitation hospitals and excluded rehabilitation units must also submit evidence of compliance with the medical director requirement. Psychiatric units must submit evidence of compliance with patient assessment and staffing requirements.

The following process will be used for IPPS-exclusion attestation and documentation:

- (a) The SA will send to the provider the attestation statement and appropriate CMS-437, along with the standard packet of certification forms and documents, within 10 working days of the earlier of the following two dates:

- Receipt of the provider's letter of intent to open for service and to seek IPPS exclusion; or
 - Receipt of the Fiscal Intermediary's recommendation for approval of the 855 application.
- (b) In the case of rehabilitation hospitals or rehabilitation units, the SA will also request that the provider attach (to its completed certification packet) documentation that permits verification that the provider has a qualified medical director who meets the regulatory standards at 42 CFR 412.29(f).
- (c) In the case of psychiatric units, the SA will also request that the provider attach to its completed certification packet the following information:
- Medical record protocols to permit verification that each patient receives a psychiatric evaluation within 60 hours of admission; that each patient has a comprehensive treatment plan; that progress notes are routinely recorded; and that each patient has discharge planning and a discharge summary.
 - A description of the type and number of clinical staff, including a qualified medical director of inpatient psychiatric services and a qualified director of psychiatric nursing services, registered nurses, licensed practical nurses, and mental health workers to provide care necessary under their patients' active treatment plans.
- (d) The provider should return the completed certification packet, along with all other requested materials, to the SA no less than 90 days prior to the start of the facility's first or next cost reporting period, as applicable, in order for the RO to have sufficient time to make a determination to approve or deny the provider's IPPS exclusion status. If the provider submits the application less than 90 days in advance, CMS will continue to process the application, but the provider assumes the risk that the RO review may not be completed in time for payment at the excluded rate to start with the first or next cost reporting period.
- (e) The SA will act promptly to review the completed packet and will forward it to the RO as soon as possible in order to permit a final certification determination prior to the start of the provider's cost reporting period.

4. Psychiatric Unit or Rehabilitation Hospital/Unit IPPS Exclusion Removal: If CMS removes the IPPS exclusion status of a psychiatric unit or a rehabilitation hospital or unit, the hospital may subsequently seek excluded status again. In such cases the hospital is required to operate for at least twelve months under the IPPS while continuing to provide the applicable psychiatric or rehabilitation services that comply with the exclusion requirements.² The facility must apply for IPPS exclusion status in the same way as a provider seeking first-time exclusion. **However, in the case of a hospital or unit that has had its IPPS exclusion status removed, the requirement for onsite verification by the SA of compliance with the exclusion criteria for psychiatric or rehabilitation services will remain in force, and such surveys will be a Tier 4 priority.**

² The twelve month requirement refers to the cost reporting period, and may be found at 42 CFR 412.25(c) and 412.25(f) for IPPS-excluded units of a hospital, and 42 CFR 412.23(h) and 412.23(i) for rehabilitation hospitals.

Appendix B - Example of Content for a Potential Provider Communication

Dear _____

We appreciate your request to be certified for participation in the Medicare program. Due to very substantial federal resource limitations, we must currently adhere to a careful priority schedule as we respond to requests from providers that newly seek to participate in Medicare. We hope this letter is helpful to you in understanding your options in this difficult situation.

Two independent and important steps in becoming a Medicare provider are:

Form CMS-855: Form CMS-855 contains background, contact, service, and provider or supplier information that is essential to the approval process. The applications are reviewed and recommended for approval or denial by the Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs) under contract with the Centers for Medicare & Medicaid Services (CMS).

Certification: Most types of providers, and some suppliers, are required to demonstrate that they are in full compliance with Medicare quality and safety requirements. This demonstration is accomplished during an onsite survey conducted by trained and qualified surveyors from the State survey agency (SA) pursuant to an agreement with CMS. There is no charge to the provider or supplier for initial CMS surveys or any later CMS recertification survey. The CMS-855 must have been approved and the provider fully operational in order for a survey to be conducted.

Some provider/supplier types have the additional option to be accredited by a CMS-approved accreditation organization (AO), and such accreditation is “deemed” to be equivalent to a recommendation by the SA for CMS certification. The attached list provides contact information on each such AO, as well as information regarding the types of providers/suppliers for which deeming applies. Note that deeming does not apply to some provider types, such as nursing homes and dialysis facilities.

CMS instructs States to place a higher priority on recertification of existing providers, on complaint investigations, and on similar work for existing providers than for initial surveys of providers or suppliers newly seeking Medicare participation. **Due to severe resource limits for Medicare survey & certification functions, in most States few providers that have an AO option will be surveyed by CMS or the State.**

Short-term acute care hospitals, rehabilitation hospitals, critical access hospitals (but not their distinct part psychiatric and rehabilitation units), home health agencies, hospices, and ambulatory surgical centers all have the option of deemed accreditation. Applicants have the option of applying to one of the CMS-approved AOs. The attachment to this letter conveys the requisite contact information.

Providers may apply by letter to the SA for CMS consideration to grant an exception to the priority assignment of the initial survey if lack of Medicare certification would cause significant access-to-care problems for Medicare beneficiaries served by the provider or supplier. The SA may choose whether to make a recommendation to CMS before forwarding the request to CMS.

There is no special form required to make a priority exception request. However, the burden is on the applicant to provide data and other evidence that effectively establishes the probability of adverse beneficiary health care access consequences if the provider is not enrolled to participate in Medicare. CMS will not endorse any request that fails to provide such evidence and fails to establish the special circumstances surrounding the provider's or supplier's request.

CMS recognizes that special circumstances apply to certain types of providers or suppliers, and has made special priority allowances for them. Both dialysis facilities and transplant centers, for example, are afforded a higher priority compared to certain other providers/suppliers because there is no AO option available, end-stage renal disease patients and transplant patients have a unique reliance on Medicare for their care, and access is often an issue.

Hospitals that are applying for rehabilitation hospital status or for an IPPS-excluded unit(s) for rehabilitation and/or psychiatric services **and that have (or will have) attained AO accreditation from a CMS-approved AO for their general hospital operations** will be allowed to submit an attestation of compliance with Medicare requirements by their PPS-excluded unit(s). In addition, they will be required to complete a Form-437, Form-437A, or Form-437B, as applicable, in addition to the attestation. This will avoid the need for both an AO accreditation survey and an on-site PPS-verification survey by an SA, since there is no AO option for verification of such IPPS-excluded units. If you are in this situation, please communicate with the SA as early in the process as possible.

We regret that the resource limitations under which we operate may complicate the process of enrolling in Medicare as a certified provider or supplier.

Appendix C - CMS-Approved Accrediting Organization Contact Information CMS

Organization	Provider Type	Name	Address	Work Number	Fax Number	E-Mail Address
Joint Commission (JC)	Hospitals, HHAs, Hospice, ASCs, CAHs	Kurtz, Trisha	601 13 th Street, NW Suite 1150N Washington, D.C. 20005	202-783-6655	202-783-6888	pkurtz@jcaho.org
	Labs	Steffens, Kathie	One Renaissance Boulevard Oakbrook Terrace, IL 60093	630-792-5785	630-792-4885	ksteffens@jcaho.org
		Peck, Margaret		630-792-5287		mpeck@jcaho.org
American Osteopathic Association (AOA)	Hospitals, CAHs, ASCs	Reuther, George	142 East Ontario St Chicago, IL 60611-2864	312-202-8060	312-202-8360	greuther@hfap.org
	Hospitals, CAHs, ASCs	Beem, Karen	142 East Ontario St Chicago, IL 60611-2864	800-621-1773 Ext. 8066	312-202-8360	kbeem@hfap.org
	Labs	Thompson, Carol	142 E. Ontario St. Chicago, IL 60611	312-202-8070	312-202-8370	cthompson@hfap.org
Community Health Accreditation Program (CHAP)	HHAs, Hospice	Surrency, Gale	1300 19 th Street NW Suite 150 Washington, D.C. 20036	202-862-3413 800-656-9656, ext. 12	202-862-3419	gsurrency@chapinc.org
Accreditation Association for Ambulatory Health Care (AA-AHC)	ASCs	Gravesville, Meg	5200 Old Orchard Road Suite 200 Skokie, IL 60076	847-853-6073	847-853-9028	mgravesmill@aaahc.org
	ASCs	Villanueva, Michon	5200 Old Orchard Road Suite 200 Skokie, IL 60076	847-853-6063	847-853-9028	mvillanueva@aaahc.org
American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)	ASCs	Pearcy, Jeff	5101 Washington Street Suite 2F P.O. Box 9500 Gurnee, IL 60031	847-775-1970	847-775-1985	jeff@aaaasf.org
Accreditation Commission for Health Care, Inc (ACHC)	HHAs	Cesar, Tom	4700 Falls of the Neuse Rd Suite 280 Raleigh, NC 27609	919-785-1214	919-785-3011	tcesar@achc.org
American Society of Histocompatibility and Immunogenetics (ASHI)	Labs	McElroy, Melissa	90 West County Rd C Suite 300 St. Paul, MN 55117	651-487-2806	651-489-3387	Melissa@cmehelp.com

Organization	Provider Type	Name	Address	Work Number	Fax Number	E-Mail Address
	Labs	Zachary, Andrea Leffell, Mary	Johns Hopkins Immunogenetics Laboratory 2941 E. Monument St. Baltimore, MD 21205	410-955-3600	410-955-0431	aaz@jhmi.edu msl@jhmi.edu
College of American Pathologists (CAP)	Labs	Daniels, Amy Driscoll, Denise	325 Waukegan Northfield, IL 60093	847-832-7471 847-832-7243	847-832-8471	adaniel@cap.org ddrisc@cap.org
Commission on Laboratory Accreditation (COLA)	Labs	Harkins, Mina Patel, Alka	9881 Broken Land Pkwy Suite 200 Columbia, MD 21046	410-381-6581 X 500 410-381-6581 X 573	410-381-8611	mharkins@cola.org apatel@cola.org
American Association of Blood Banks (AABB)	Labs	Sullivan, Judy Rapp, Holly	8101 Glenbrook Rd Bethesda, MD 20814	301-215-6540 301-215-6523	301-907-6895	jsullivan@aabb.org Holly@aabb.org